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BETTER CARE FOR MOTHERS AND BABIES

IN THE HISTORIC East Room of the White House on the morning of January 18, the portraits of George and Martha Washington looked down on a nationwide gathering of men and women assembled in a two-day conference to discuss a plan of action for the protection of the motherhood and the childhood of the nation. Rich with memories of similar occasions—reaching back through the years to 1909 when Theodore Roosevelt welcomed here the first national conference on child health—this spacious, light room with its cream-colored walls and red hangings furnished an appropriate setting for the second morning of the Conference on Better Care for Mothers and Babies.

Five hundred delegates from 86 professional and lay groups responded to the call of the Children's Bureau to canvass the resources available for meeting the problem of needless maternal and infant deaths. Forty-three states, the District of Columbia, Alaska, and Hawaii sent representatives to this conference, which was opened at the United States National Museum by Katharine Lenroot, Chief of the Children's Bureau.

The opening address of welcome by Frances Perkins, Secretary of Labor, laid out the task for the conference. Miss Perkins envisioned the pattern which is emerging in this country of citizen-groups combining with government in planning for the social good. She pointed to the change which is occurring in the fatalistic attitude toward preventable deaths of mothers and babies, and called for a study of the factors which make maternity hazardous—economic and professional factors, and the need for community resources for proper care. Both Miss Perkins and Dr. Thomas Parran, whose address followed hers, stressed the close relationship between poverty and the deaths of mothers and babies, a fact long realized, which has been overwhelmingly corroborated by the recent National Health Inventory.

Dr. Parran, Surgeon General of the United States Public Health Service, urged an integration of the maternal and child health program with the whole public health program. He said that no problem of family health can be isolated from the other problems, and reminded his hearers that the taxpayer bears the high cost of the end results of preventable diseases such as tuberculosis, pneumonia, syphilis, and cancer which could

be more economically controlled by earlier care. He recommended adequate federal subsidy to state and local communities in order to equalize the financial burden of health needs and make possible medical care based primarily on medical need—and not on the pauper's oath.

The essentials of good maternal and infant care were explained by specialists in obstetrics and pediatrics. The economic, professional, and community resources which are involved in extending adequate care to mothers and babies were outlined, and the great need for higher standards of professional care on the part of all groups which contribute to maternal and child health was frankly admitted.

With one of his usual incisive thrusts the dynamic little mayor of New York City—Fiorella H. LaGuardia—brought to a focus the real problem: "What we need is not ideas; what we need is money!" The value of existing lay organizations for interpreting the problem to the public and stirring them to action emerged from the evening forum of open discussion under the adroit leadership of Mrs. J. K. Pettengill, president of the National Congress of Parents and Teachers and chairman of the Planning Committee of the conference.

Special committees worked during the conference summarizing its findings as a basis for future procedure, and a continuing committee was appointed to carry on the aims and efforts of the conference. Of special interest to nurses is the recommendation of the Committee on Community Resources that the professional staff administering a state maternal and child health program should include a staff of thoroughly qualified public health nurses, with a director and regional assistants to administer and supervise the public health nursing in the field, and also nurses with special training in midwifery to supervise the midwife deliveries where this need exists.

To carry out a constructive plan of action will in the opinion of the Findings Committee call for an amendment of Title V, Section 502, of the Social Security Act to authorize a larger sum to be appropriated annually to the states for maternal and child health services—to the point that will insure proper care to all mothers unable to obtain such care because of economic reasons or inaccessibility to good care.

P.P.

STUDENT AFFILIATION

LAST MONTH in this magazine, the Education Committee of the National Organization for Public Health Nursing made certain recommendations regarding student affiliation with public health nursing agencies by schools of nursing.* These suggestions have been long awaited. The N.O.P.H.N. is asked certain other questions in connection with student affiliation which were not within the province of these recommendations.

1. Is it the responsibility of a community nursing agency to share in the educational preparation of nurses through offering supervised experience to undergraduate students?

The N.O.P.H.N. believes that this is the responsibility of the community nursing agency only under these conditions:

That the school of nursing is conscientiously attempting to establish a curriculum which follows the new *Curriculum Guide* published by the National League of Nursing Education.

That the public health nursing agency and the school of nursing fulfill the prerequisites as listed for each in the published recommendations.*

That the school of nursing bears the cost of the affiliation.

2. When a local agency with limited facilities is requested to give experience to graduate nurses from approved public health nursing courses, to faculties of

*"Student Affiliation." PUBLIC HEALTH NURSING, January 1938, p.15.

schools of nursing, and to undergraduate nurses, the question arises as to which should be given preference.

Various considerations enter into this decision. On the one hand, graduate nurses from approved public health nursing courses have made their choice of this field and invested their money in preparation for it; moreover, they are greatly needed in the field. Again, it is important to see that graduate nurses who are faculty members and head-nurses in schools of nursing have the opportunity to obtain a public health point of view. And finally, there is the greatly increased demand on the part of schools of nursing to secure affiliations for their students.

A joint committee of the National League of Nursing Education and the N.O.P.H.N. has been formed to study this whole problem. In any case, public health nursing agencies may offer a definite service to schools by acting as consultants in regard to the health aspects of the curriculum. Emphasis should be placed on the fact that the introduction of health into the entire curriculum is the first step to be taken by the school.

3. If a student nurse proves unsatisfactory in the field of public health nursing, who takes the responsibility for her withdrawal from the field?

The public health nursing agency reports to the school of nursing and the school withdraws her from the affiliation. A series of withdrawals might indicate an unsatisfactory basis of selection of students, inadequate preparation in the school, or personnel difficulties in the public health nursing association.

4. Where can the public health nursing agency find out about the standing of the school of nursing requesting affiliation?

The state board of nurse examiners or the National League of Nursing Education can give this information.

5. Where can the school of nursing find out about the standing of a public health nursing agency which offers to give an affiliation?

The N.O.P.H.N. hopes that the state board of nurse examiners will soon have made some plan for accrediting for teaching purposes those public health nursing agencies whose practices are in accord with accepted principles as outlined by the N.O.P.H.N. Other sources of information might be the nearest endorsed course in public health nursing (see page 109 for a list of approved courses) and also the N.O.P.H.N. itself. Directors of nurses in state departments of health and regional supervisors in the nursing services of the federal agencies also know the general standing of local agencies.

6. Is a graduate nurse of a three-year course who has completed her affiliation with a satisfactory record eligible for consideration for a staff nurse position in a public health nursing agency?

If her qualifications meet the standards of staff appointment in that agency. Her eligibility for advancement, however, will probably be dependent on her further preparation in the field by taking an approved course in public health nursing. D.D.

Public Health Nursing Aspects of Pneumonia Control

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The channels for pneumonia control are specific serum therapy and skilled nursing care. The function of the public health nurse in regard to both is described here

IT SEEMS STRANGE that only during recent years, professional and public interest has turned toward the problem of pneumonia control. The indifference of the past cannot have been because pneumonia was not a dreaded disease, for its seriousness has been recognized, at least in an individual sense, for many generations. It cannot have been because it was not a spectacular disease, for it is certainly among the most dramatic and impressive of illnesses. The most plausible explanation seems to be in a combination of facts. It is likely that pneumonia was not recognized outside of certain circles as a disease ranking among the foremost causes of death. It is not limited to class or race. It does not often appear to occur in great epidemics. It is universally and widely scattered so that people expect it and have become accustomed to it. Probably most important of all, it was formerly felt that nothing could be done about it. This attitude resulted in enveloping the general reaction toward the disease in a mistaken atmosphere of fatalism.

Such beliefs have persisted in many parts of this country up to the present, despite the fact that the solution of a large part of the problem was first pointed out over twenty years ago.[1] Today, although we recognize that this disease constitutes one of our major public health problems, we find reason for encouragement inasmuch as we have at our command methods for its control which have given proof of their effectiveness.

Since the extent of pneumonia as a public health problem has been ably presented in two previous articles in this magazine,[2, 3] only a few facts will be mentioned which may serve to bring the problem more sharply into focus. Such facts as the following will prove of value not only in refreshing the memory of the public health nurse, but also in aiding her to present more graphically this new health problem to the general public:

Pneumonia ranks among the first three of all causes of death in the United States and Canada

It is the greatest cause of death of all infants under two years of age, except premature birth

It is the real cause of death in approximately half of the fatalities from such diseases as whooping cough and measles

It causes more deaths in this country than all other communicable diseases combined (excluding tuberculosis), and that fully 35% of the deaths from pneumonia occur in the wage-earning groups

It is essential that the general public, as well as the members of the medical and nursing professions, appreciate the nature of the problems with which the public health worker is faced since it is this same public which finally must be called upon to determine the nature and extent of control measures which shall be applied.

More or less by habit, we have come to think of communicable disease control in the preventive terms of sanitation, immunization, or isolation. As tempting as it is to embark on a discussion of the theoretical application of such measures to the pneumonia problem, the fact remains that we lack sufficient scientific knowledge or practical experience to do so. Of necessity, therefore, our efforts to control pneumonia must find more suitable channels. We have such channels. They are concerned with the wider and more effective application of therapeutic measures now at our command. The first of these is *specific serum treatment;* the second, *skilled bedside nursing care.* Both are now generally accepted as vital and life-saving contributions to the proper treatment of pneumonia.

In 1932 Dr. Carl Buck stated in this journal that "The control and prevention of communicable disease is primarily the responsibility of the individual and the family. The educational efforts of the public health nurse constitute the most important factor in developing the individual's sense of responsibility."[4] Both of these statements are particularly true and important in such a swift-moving and acute disease as pneumonia.

The widespread publicity which pneumonia as a public health problem has been receiving quite naturally gives rise to this question from the public health nurse, "Where do I fit into this picture?" The feelings prompting this question are easily understood. The areas and functions covered by the term *public health nurse* vary from the few city blocks in which the visiting nurse gives intensive bedside care to the county unit which is frequently equal to the area of a small state, and in which one nurse attempts the broad objective underlying all public health nursing activities—the safeguarding of health and life. Frequently such a wide range of public health nursing services can be found within the boundaries of one state. This is true of New York State, for example, with its large cities and sparsely settled rural areas.

The New York State Department of Health has had for the past two years a definitely established pneumonia control program. The objectives of this program were previously outlined in this journal by Marion Sheahan[2] and are restated here for the purpose of examining each one for its implied public health nursing functions.

EARLY FINDING OF CASES

1. *Emphasis to physicians of the importance of early diagnosis of pneumonia based on symptomatology and laboratory tests to determine types.*

The physician can do little to favorably influence the outcome of the illness unless he is called soon enough to provide adequate general care and specific serum treatment in suitable cases, during that early stage of the disease when these measures are known to be of the greatest value. The community nurse, as home visitor, frequently sees or hears of the suspicious or early case and can be instrumental in securing medical supervision for it. As a community health teacher, she is in a strategic position to drive home the realization of the importance of prompt medical attention.

Scientific research is making the home administration of antipneumococcus serum increasingly easy for the practicing physician, and as serum becomes more commonly used outside of hospitals there will undoubtedly be greater demands for nursing assistance in giving it. If the number of nurses in an area is too small to make such a service feasible, the local welfare officer or other interested agency may often be prevailed upon to finance a special nurse for the medically indigent patient. The services of the nurse so obtained might also be extended to the bedside care of such a patient during the acute illness.

It should be kept in mind that before the nurse can be of any real help in the control of pneumonia in her community, she must have a knowledge of pneumonia, its manifestations in the individual and the community, and the specific methods employed to fight it. The bibliography published by Margaret Reid[5] should serve as an excellent guide to nurses in seeking such detailed information.

SPEEDING OF LABORATORY SERVICE

2. *Extension of approved laboratory service for rapid sputum-typing (Neufeld method) to determine whether serum is indicated in treatment.*

Obtaining a satisfactory specimen of sputum for typing is the first requisite for serum administration. Its importance and the matter of obtaining it without undue exertion to the patient are all essential teaching points for the nurse to know.

Even in New York State, where laboratories providing sputum-typing facilities and serum distribution are fairly numerous, the distance to them often represents a considerable journey for the physician and a serious loss of his valuable time before he can learn what the type of a given case may be. To answer this problem, messenger services, rendered by boy scouts or specially organized lay groups under the guidance of the nurse, have been formed in a number of rural communities in New York State. The physicians are provided with a list of the names and addresses of these volunteers and know that they may call upon them day or night, when necessary, for the purpose of taking sputum or other specimens to the laboratory and bringing back serums for cases in which they are indicated. Careful administration of serum is a long procedure and any service is worth while which will aid the physician in giving this treatment without disrupting the remainder of his day's work.

It is important for every nurse to know the location of the nearest source of serum and laboratory where typing may be done.

INTERPRETATION OF IMMUNIZATION

3. *Production and distribution, without cost, to physicians of type specific antipneumococcus serums.* (Types I, II, V, VII, and VIII are now available in New York and several other states and more types will undoubtedly be added as they are produced and shown to be of value.)

Every nurse occasionally has to listen to fallacious ideas and prejudices which are based on a few unfortunate and unexplained serum or vaccine reactions in her community. The nature and value of these treatments are so often misunderstood by the lay public.

Pneumonia serum has been discussed in magazines, newspapers, and over the radio and much that is not understood by the public will be referred to the nurse for explanation. Vaccines and serums in their relation to active and passive immunity can be made interesting and understandable even to lay people and the nurse should be prepared to meet lay interest with accurate information regarding them.

The cost of adequate treatment with pneumonia serum, if privately purchased, would be almost prohibitive for the average family. Therefore, in order to effect its wider use, some arrangment should be made by state or local governments for its free distribution. Where this cannot be done, a community fund for such treatment might be established through the physicians' and nurses' efforts. The financial outlay for this will in the long run, probably be much less than the cost of deaths and disabilities of untreated pneumonia patients.

ASSISTANCE WITH STUDIES

4. *Appropriate research studies.*

There is still much to be learned regarding the incidence of the several types of pneumonia, the preparation of

serums, the method of spread of the disease, and the value of serum and oxygen therapy and nursing care. It is important to remember that studies based on these needs are essential to any progress in meeting the total problem satisfactorily.

It may be possible for the nurse to aid the physician to return the report forms which come with serum to the laboratory supplying it. This information is necessary for clinical evaluation of the serums in current use.

Efforts are being made in selected areas throughout New York State to determine just how communicable pneumonia is. Nurses in these areas visit the homes of reported pneumonia cases and obtain information regarding diagnosed secondary cases and respiratory illness among members of the patient's family. The results of this study may help to decide to what extent home isolation technique should be developed.

Another study in New York State was done by the nurses in an effort to determine the nature of nursing care given to pneumonia cases in both rural and urban areas. It was found that more than half of the patients who were not hospitalized did not have the benefit of any skilled nursing care during their illness.

The value of such studies and the nurse's contribution to them are obvious. The nurse who approaches these practical problems with an understanding of the importance of her task will not only find it stimulating, but also will do better work.

THE NURSE AS A TEACHER

5. *Dissemination of appropriate knowledge regarding the cause, nature, and treatment of pneumonia to all groups concerned; physicians, nurses, and the general public.*

Aside from the physician, there is no one in the community in a better position than the nurse to build up in the lay mind an accurate body of facts regarding pneumonia. Her pupils range from the housewife at the bedside to such organized meetings as those of parent-teacher associations or home bureau groups. The public appear to be manifesting an intense interest in the pneumonia problem and the health teacher should make every effort to base her appeal for community coöperation on this interest.

Special instruction on the part of the nurse in serum and oxygen therapy should be accessible to all nurses. The means of obtaining it may vary from individual instruction at hospitals using these treatments to organized programs of staff education. It is wise to remember that new procedures are often adaptations of old techniques in which most nurses have had training. It should, therefore, be possible for the nurse to weave the majority of these new facts and techniques into the fabric of her previous knowledge.

NURSING CARE OF PATIENT

6. *The provision of facilities for adequate bedside nursing care.*

Prior to the institution of serum therapy, physicians generously acknowledged that good nursing care was probably the one factor which could influence the course of pneumonia more than any other single factor. As previously mentioned, recent studies indicate that unhospitalized cases of pneumonia are not receiving adequate nursing care. This is indeed a challenge to public health nursing organizations. Many communities are meeting this challenge in a very constructive manner.

In some instances, visiting nurse organizations are providing two visits a day during the critical stage of the disease, and may, upon occasion, provide special nursing care for varying lengths of time even to continuous bedside care. The latter degree of service is not infrequently provided under subsidy from certain of the larger insurance companies who may employ the service of these

nurses. This fact alone should indicate strongly the importance of such care. Rural areas usually cannot offer such extensive service. In such circumstances, nursing visits, if they can be provided at all, may vary from one daily visit to one visit during the entire illness for care and instruction. When nursing facilities are such that home visiting is not possible, the nurse's effort in emphasizing the need for this service may aid in achieving it.

Although constant bedside nursing is ideal for the pneumonia patient, even a single visit in which the essentials of care are demonstrated to some member of the family should prove of great value to both the patient and attendant.

Bedside care of the pneumonia patient has been very clearly outlined in a recent article by Evelyn Mercer.[6] "The Handbook on the Nursing Care of Pneumonia,"[7] which is freely available to all graduate nurses should, if combined with the nurse's fundamental knowledge of nursing procedures, serve as a useful guide in giving care or instruction.

There are few diseases which so challenge the efforts of the public health nurse as does pneumonia, not only because of its seriousness, but also because of the difficulties attending its care. Furthermore, it is safe to say that no control efforts can be effective without the active participation of the people for whose welfare they are made. In enlisting this active interest the nurse-teacher is absolutely essential.

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Nutrition and the Maintenance of Health

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What is the bearing of nutrition on the prevention of disease and the maintenance of health? An authority in this field discusses some important dietetic needs

SINCE public health service embodies largely the preventive aspects of medicine, nutrition should play a prominent part in all its phases. The rôle of diet in both the prevention and amelioration of disease is only the negative statement of its true place in the drama of health. As a result of well chosen diet, positive improvements in rate of growth, adult size, beauty and vigor, endurance, retention of youthful characteristics, and longevity have been demonstrated in experimental animals and are gradually being recognized in the human records. All those whose duty it is to serve public health in any fashion must know the truth about nutrition if they are to fulfill that duty satisfactorily.

The truth about nutrition is not yet fully known but enough of it has been uncovered to prove definitely that physical and perhaps also mental health are dependent upon proper diet. Pregnancy, lactation, infancy, childhood, and adolescence are the critical periods during which a wise choice of food is most necessary and the penalties of wrong choice most severe. But the adult—young, middle-aged, and old—is also subject to these penalties and in addition to further risks of tissue degeneration from the accumulated residue of earlier deficits or excesses.

What are these penalties? In pregnancy, latent or open beriberi, loss of appetite, possibly the toxemias (especially those of early pregnancy), anemias, thyroid enlargement, and tooth and gum damage are only the visible results of various dietetic deficiencies.

Lactation damage is not so easily enumerated because in most cases the milk flow is inadequate or wholly lacking, the infant is weaned at once, and the burden of deficiency is thus shifted from the mother. From observations on animals, however, it is necessary to conclude that dietetic errors are likely to cause graver damage during lactation than during pregnancy.

The breast-fed infant has a good deal of protection against nutritional errors, but at the grave expense of his mother. He still is subject—though in far less degree than the bottle-fed infant—to rickets, anemia, latent scurvy, subnormal growth (both physical and mental), eye defects, tooth decay, and the infections following the rachitic deformation of thoracic and pelvic framework as well as that of the throat and nasal passages. What part these early partial deficiencies in the vitamins A and D may play in laying the ground work for tuberculosis, sinus infections, tonsil involvement, and other respiratory diseases remains to be fully explored. But these infections seldom develop in laboratory animals unless partial dietetic deficiencies are first established.

Adolescents are particularly prone to fall victims to rampant caries, anemia, goiter, and skin diseases. The mature adult who may have escaped the deficiency stigmata faces the degenerative changes produced by long-continued use of too much of the wrong foods. Blood

vessel, heart, and kidney degeneration await the adult who has survived both the deficiencies and the infections of youth. There is no academic proof that these degenerative diseases of old age result from mistakes in diet but the presumptive evidence is strong.

The rôle of diet in the *treatment* of disease is also of grave importance, particularly of course in most of those caused by nutritional faults. In some cases, such as diabetes, pernicious anemia, nephritis, gastrointestinal derangements, and allergies, the treatment must be largely by dietetic means even though the disease can not be said to be caused by dietetic errors. Good diet is advisable in all cases for the sick as well as the healthy, but discrimination must be exercised in the assignment of the chief curative rôle to diet. Unfortunately many serious ailments cannot be attacked by any dietetic means now at our disposal. Only harm can result from the too enthusiastic application of a magic rôle to good nutrition.

Following is a brief summary of the practical conclusions generally agreed upon at this time concerning the bearing of nutrition on the maintenance of health:*

DIETETIC NEEDS IN PREGNANCY

What is known about dietetic needs in pregnancy? The caloric requirement is thought to be increased only in proportion to the increase in body weight. Any further increase in total food intake is therefore of doubtful value, particularly since changes in the mother's intake must be extraordinarily and dangerously large if any effect upon the size of the fetus is to be achieved.

The protein retention is found to be astonishingly large compared with the protein content of the uterus. Where this excess protein, estimated at 200 to 300 grams, is stored and what purpose it serves are unanswered questions. It is often said that this represents a provision in advance for the drain of lactation. I have wondered whether it may be altogether an advantageous phenomenon and may not in part represent an undesirable retention of nitrogenous end-products. The dangers of the late toxemias with kidney involvement must be kept in mind in advising a protein-rich diet, and from clinical observation caution in the use of meat is especially recommended. Milk, eggs, cheese, cereals, and vegetables are perhaps the best sources of protein in pregnancy.

Another outstanding change in pregnancy is in the mineral metabolism. Relatively large amounts of calcium and phosphorus are retained in the last three months and these are best used when vitamin D is supplied also. Again milk, cheese, eggs, green vegetables, codliver or other fish-liver oil, and sunshine are indicated. A large excess of the alkaline mineral elements is retained in late pregnancy, indicating the desirability of supplying an alkaline diet. This excess alkalinity is actually only an expression of the greatly increased calcium need.

The anemias of pregnancy are troublesome. There may be two types of nutritional defect involved in anemia production—a lack of iron and possibly copper, and a lack of the vitamin B_2 complex. Liver and liver extracts, yeast and rice polish or their extracts supply the latter; vegetables, whole cereals,

*Reviews of the scientific evidence in the field are available in the greatly increased modern scientific literature on nutrition. *The Journal of Nutrition, Food Research, Journal of the American Dietetic Association,* and *Nutrition Abstracts and Reviews* (Scotland) are four periodicals concerned solely with the problems of food and nutrition, which have begun publication since 1928. In the last year several of the outstanding texts or reference books on nutrition have appeared in a new revised edition and at least two important new ones have appeared. Every medical, dental, nursing, veterinary, and agricultural journal has an increasing number of articles and editorials on nutrition. The League of Nations Health Organization is issuing a series of stimulating bulletins on nutrition, agriculture, and health, and our own government bureaus are outdoing themselves and one another in studies of the same kind.

meats, egg yolk, and many other foods the former.

DIET IN LACTATION

The nursing mother needs most of all probably a high protein diet. Perhaps the caution of late pregnancy in lowering the meat intake may be partly to blame for some early failures in milk supply. Too low intake of protein and too low vitamin B_1 intake are the two food factors which have the earliest and most disastrous effects upon the milk flow. The nutritive quality of the milk is affected definitely by the level of vitamins A and C, by the food iodine, and possibly also by the food iron and the vitamin D. In most of these respects, human milk is more subject to modification by the mother's diet than is cow's milk by the cow's feed.

Protection of the nursing mother herself is especially necessary in regard to calcium and phosphorus. Indeed it seems almost impossible to prevent loss of these elements from the body of all milk-producing animals as well as the human subject. Dairymen are more or less resigned to allowing rest periods between lactation cycles for the restocking of the cow's body with calcium and phosphorus. The human mother certainly needs such an interval for the same purpose.

NEEDS OF THE INFANT

The newborn infant enters a period of hemoglobin loss as soon as it is born and such loss apparently can be made up only from the iron reserves in the liver unless the milk diet is supplemented promptly. By the end of the first year nearly all bottle-fed and most breast-fed infants are definitely anemic. This anemia is of the same kind produced in experimental animals by exclusive milk feeding and is due to the low iron content of milk. Inorganic iron has been shown to be absorbable and organic iron largely unabsorbable. Consequently total iron figures for food are of only limited value. Perhaps a few drops of simple inorganic iron salt solution added to the milk mixture will some day be generally used to meet this infant need.

Vitamin C is poorly supplied by cow's milk and is rather variable in human milk. Infants should receive orange juice or some other source of this vitamin after the first few days of life. Pure crystalline ascorbic acid now available may be used to supplement the fruit juice, but there is reason to believe that it cannot take its place entirely.

Codliver oil or similar fish-liver oil, preferably in concentrated form, largely freed from fat, must also be given to prevent rickets and tooth damage and also to supplement the vitamin A of the milk fat. Exposure to sunshine or ultraviolet irradiation must be cautiously guarded and viosterol administration interdicted except under exceptional circumstances. The danger of excess vitamin D intake in the form of viosterol, especially, is real in spite of inspired propaganda to the contrary.

THE GROWING CHILD

Milk is poor in vitamin B_1 and there is plenty of evidence that young children suffer from this deficit. Failure of young children's appetite is the great worry of most mothers who are awake to the importance of feeding, and indeed the more conscientious the mother the worse the anorexia. This may be because overfeeding with milk, fruits, and vegetables, all low in vitamin B_1, depresses the appetite which is definitely dependent upon this vitamin for its functioning. Whole grains, lean pork, dry legumes, and nuts are the only rich sources of vitamin B_1 among natural foods. Wheat germ, dried pinto beans, rice polish, peanuts, dried soy-beans, cottonseed flour, and lean pork are the only foods containing three units or more per gram listed in the recent compilation by the Bureau of Home Economics, Vitamin Content of Foods.

(Miscellaneous Publication 275, June 1937.)

No wonder a diet made up of white bread, cream of wheat, butter, sugar, fruits, cookies, jelly, milk, and scraped lamb, chicken, or beef will not produce appetite in children. Adults have developed appetite as a psychological feat and in them its manifestations have little to do with either hunger, food need, or lack of need. But children acquire this urge only slowly and usually not before the age of eight or ten years. Until then a generous supply of vitamin B_1 is indispensable. If vitamin B_1 extracts such as those from yeast or wheat germ were generally used for infants much of this difficulty with appetite might be avoided.

A high-protein diet, at least three grams per kilogram of body weight per day, is now known to be desirable for children, probably throughout the entire growth period. Only a few years ago one half of this amount was usually advocated. Milk, eggs, and meat are the foods of choice for a large part of this protein. The quantity actually needed, for example, for a boy of eight years weighing 66 pounds, is 90 grams, which would be a generous supply for any adult. This would require 1½ pints of milk providing 22 grams of protein, 2 eggs containing 14 grams of protein, 6 slices of whole-wheat bread containing 20 grams of protein, 4 ounces of lean meat containing 27 grams of protein, the cereals, vegetables, fruits, and other foods making up the remaining 6 or 7 grams required. This may sound like a large order of food for a small boy but these foods carry only 1400 of the 2200 calories such a child needs. Too many children receive far less than this minimum of protein.

PROBLEMS OF MIDDLE AGE

But in the middle-aged and elderly adult there may be wisdom in restriction of protein intake. Scientific opinion on this point has undergone several changes in recent years. Forty years ago Chittenden of Yale began his campaign for the low protein diet, with soldier, student, and prisoner squads as subjects, hoping to demonstrate better health and endurance on extremely low protein intake. The results were not convincing on the whole and a reaction in favor of more generous diet followed.

For many years meatless and saltless diets were prescribed for nephritics and arteriosclerotics. The discovery of the nephroses with their need for more protein complicated this picture and caused a swing back toward more liberal diets in all kidney diseases. The exact bearing of protein intake on hypertension and arteriosclerosis is likewise in a state of flux. In the last year or two a number of new studies have been reported which tend to support stringent restriction of protein in heart, kidney, and circulatory diseases of middle and old age. The restriction of all cholesterol-rich food is often advocated also for the prevention or treatment of arteriosclerosis. Cholesterol is found chiefly in egg yolk, brain, sweetbreads, liver, cream, and butter.

Interest in the rôle of vitamin B_1 in heart dysfunction is increasing. There is evidence of its specific rôle in cardiac failures and of the existence of latent beriberi with both neuritic and cardiovascular symptoms in our population of all ages. The importance of prevention is stressed, since administration of even heroic doses of the missing vitamin seldom brings about rapid or complete cures. Vitamin B_1 and possibly also C deficiencies may produce abnormal products of metabolism which in turn cause functional and finally structural lesions of the cardiovascular system which may be incurable.

But deficiencies pure and simple are not alone important. Vitamin deficiencies of all kinds are most injurious when the caloric intake is most generous. The peculiar susceptibility of alcoholics to every kind of nutritional deficiency is a case in point. Alcohol is a perfect

calorie producer, rapidly and easily absorbed and carrying its own appetite mechanism, independent of vitamins, with resultant manifestation of severe deficiency symptoms. The chronic alcoholic seldom suffers from one deficiency only, but shows a hodgepodge of mild indications of pellagra, beriberi, scurvy, and low-protein edema. High-carbohydrate vitamin-low diets made up of sugars, white bread, jams, refined cereals, and canned fruits and vegetables are likely to result in a similar condition.

The rôle of gastrointestinal lesions in inducing deficiency states should not be forgotten since not what is eaten but what is absorbed controls nutrition. Persons with colitis, celiac disease, and other intestinal disturbances may lose the benefit of good diet if these conditions are not corrected.

VITAMIN MINIMA REQUIRED

Attempts are now being made to evaluate the actual vitamin requirements of man but such estimates are at best tentative and represent minima below which frank deficiency symptoms develop.

Probably 5000 International units of vitamin A daily for adults and more in proportion to weight for children is the standard likely to represent such a minimum.

Vitamin B_1 should probably be proportioned to caloric intake rather than body weight, for adults perhaps not less than 20 International units per 100 calories, or 400 to 500 per day for the average active adult. As a basis for estimating what quantity of food this represents, remember that whole wheat (100 percent) bread contains about 35 International units of B_1 per ounce.

Vitamin C in the amount of 1000 International units daily for infants, 2000 to 5000 for growing children and for pregnant and nursing mothers, and 1500 for other adults are the estimates offered. Since orange juice contains 10 units per c.c., 3.5 ounces for infants, 7 to 10 for children and mothers, and 5 for other adults will provide a safe margin. Infants receiving good human milk probably get almost enough vitamin C without added fruit juice. Tomato juice has about one half to two thirds the value of orange, lemon, and grapefruit juice, and pineapple juice about one fourth.

The vitamin D need varies with exposure to ultraviolet rays so much that minimum intake by mouth can hardly be estimated. The equivalent of 1½ teaspoons of good codliver oil is probably enough for most infants and children.

The vitamin B_2 group is so much diversified and the recent research reports on it so confused that it is probably too soon to attempt any estimate of human need for it. That human beings need one or more of these factors is obvious from the occurrence of pellagra, pernicious anemia, sprue, and several other related conditions which have been produced in experimental animals by removing one or another of these factors from the diet. Vitamin G or flavin prevents dermatitis in chicks, loss of fur in rats, yellow liver in dogs, and affects growth in all of these species. Vitamin B_6 prevents dermatitis and anemia in rats, and the filtrate factor prevents black tongue in dogs and cures pellagra in man. The separate evaluation of foods for each of these factors remains to be done.

SIGNIFICANCE OF DIET

In conclusion it is suggested that diet be considered of greater importance in the maintenance of health and prevention of disease than for the treatment of disease. I believe it is safe to say that dietetic treatment never produces an absolute cure of anything, but greatly alleviates some conditions and allows comfortable and efficient living as long as it is adhered to. The greatest value of education in nutrition lies in its application to the feeding of pregnant and nursing mothers, infants, and growing

children and only secondarily in mitigation of the effects of the early mistakes of adults. Both deficiencies and excesses are embodied in these mistakes, the former operating in early life, the latter in the later adult years. More rapid growth to larger size, greater endurance, better mental balance, and longer lasting youth are the rewards of early and continuing intelligent choice of food.

Presented at a one-day institute of public health nurses, Welfare Division, Metropolitan Life Insurance Company, San Francisco, California, November 2, 1937.

This is the first of a series of three articles by the author on various aspects of nutrition. Articles on diet in pregnancy and lactation will appear in spring issues of the magazine.

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Many requests for information on the safest and most effective procedures in regard to fundamental nursing techniques are coming to the N.O.P.H.N. We will appreciate hearing from any agencies which have made bacteriological experiments in regard to hand-washing, thermometer technique, or other common nursing procedures used in the homes or schools. Please communicate with the National Organization for Public Health Nursing, 50 West 50 Street, New York, N. Y.

The Industrial Nurse's Part in the Prevention of Sickness

By PHOEBE BROWN, R.N.
Consolidated Water Power and Paper Company, Wisconsin Rapids, Wisconsin

The relation of illness to production and to accidents is a problem of increasing concern to industry today. The nurse's part in the prevention of sickness is described here

EVERY NURSE in industry has many opportunities to stimulate and participate in a program for the prevention of sickness. The extent to which the nurse enters into the sickness prevention program depends upon the type of industrial medical service which is maintained.

Some industrial plants maintain a nurse primarily for their employees' benefit association, and thus her work is chiefly that of welfare. She gives service not only to the members, but to their families as well. She has an excellent opportunity to give such employees and their families a keener understanding of good health and better living. For after all, the problem of sickness prevention concerns not only the individual employee, but also his family.

To fill her place successfully in such a program the nurse must be genuinely interested in the problems of the employees. She must have a knowledge of the personnel whom she serves—their modes of living, their idiosyncrasies, their families and environments. By keeping her ear to the ground constantly she learns of their problems so that she may help to solve them.

Naturally a knowledge of the community served is vital, for often through constructive suggestion she is able to improve the health standards of the community.

Perhaps a better conception of the sickness prevention program may be gained by an actual case analysis:

The writer was called to the home of an employee who had been reported sick at frequent intervals during the past two years. He was underweight, nervous, and irritable. On the first home visit he was found to be confined to bed and vomiting excessively. His wife said that he had attacks of this type periodically; but that he would not have a physician because his doctor did nothing for him except give him an expensive prescription and tell him to be careful what he ate.

During the attack he was careful enough, and ate nothing for two or three days. But as soon as the illness was over he went back to his old diet of meat, potatoes, plenty of spices and relishes, copious amounts of coffee, two packages of cigarettes a day, and a considerable amount of beer each week-end.

At one time the doctor had said he should have an x-ray of the stomach, but he complained that this would cost him $40, which he couldn't afford, and anyway he couldn't get away from work when he wasn't sick. He was finally made to realize that he was losing much more time and money being ill every two or three months, losing four or five days at a time, than if he were to find out just what was wrong and then do something about it.

He was referred to a clinic which was

conducted on a part-payment basis, and a complete examination was made, with x-rays and blood tests. After he was convinced of the necessity of a proper diet, his attacks became less frequent, and he gained weight and was a much more agreeable follow at work.

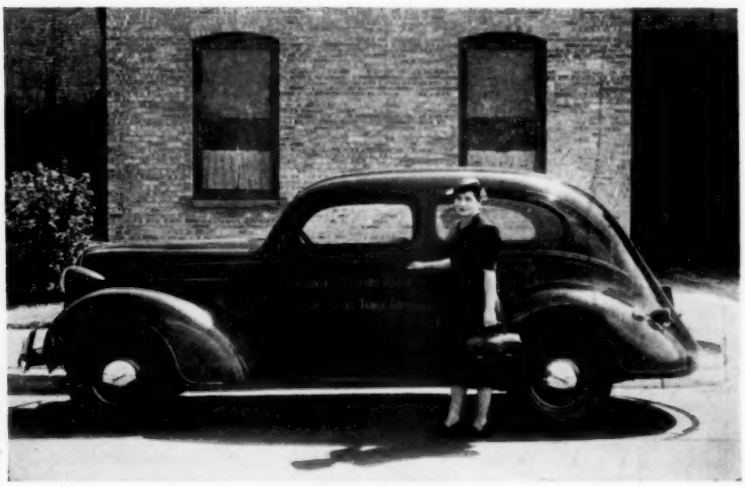
In another instance an employee's wife had undergone an operation at a local hospital. When she was visited later at home, it was learned that she was recovering satisfactorily but that there were desperate financial troubles. The husband earned $92 a month. There were seven boys in the family, the oldest 18 and unemployed. It was discovered that one of the children who was graduating from school did not even have a graduation suit. His father couldn't afford it because he was paying $5 weekly on his wife's $90 hospital bill. He was taking care of the doctor's bill by doing some repairing and cleaning in his office.

After the problem was discussed with the employee, the hospital authorities were visited. Hearing the story and realizing the effort the man was making, the hospital gladly discounted $50 from the bill. Payment of the remaining $30 was made by the Employees' Welfare Loan Fund, and this in turn was deducted from the employee's pay check at the rate of $2 a week. The total cost to the Welfare Association was slight, but the assistance and feeling of security given this employee was immeasurable.

WHAT CAN THE NURSE DO?

But let us consider the industrial nurse who serves chiefly in a first-aid department and who very seldom is in contact with the family of the employee. How does she best serve in a sickness prevention program?

Here, again, her knowledge of the personnel is indispensable. She should review the personal record of the employee with the employment manager to obtain a better understanding of the individual. This should be followed by a study of the employee's job: where he works and under what conditions, especially the sanitation; the product manufactured, and the raw materials it is made of. There the nurse may obtain valuable information as to latent hazards that eventually may affect the health of the employee, oftentimes recognized too late to be cured.



Phoebe Brown

From this and a study of past sickness she maps and carries out her program of prevention as follows:

1. By suggesting better working conditions, such as improved illumination, sanitation, housekeeping, ventilation, and the use of proper and adequate protective equipment.

2. By education of the employee to higher health standards. This requires constant efforts through bulletin boards, mass meetings, news items, and personal contacts. Articles in plant magazines are far reaching, and pay-envelope inserts discussing health topics have proved beneficial.

3. By advising and assisting the employee in securing the correction of physical defects and social maladjustments.

The following case is an example:

An employee had repeated attacks of rheumatism and had been advised by the family physician to have his teeth extracted, but he did not know where he would get the necessary dental fee.

Our plant had introduced a plan whereby our employees were allowed dental services, in special cases, through the Welfare Association. If an employee was a reliable workman and had been with the company for more than six months, his financial condition was investigated. If he were honest but having a difficult time establishing his credit, he was given an order to one of three dentists whom we were assured were giving our employees fine dental care at a minimum charge. The dentists were glad to render this service, for they were not only sure of their accounts but were also increasing their practice by developing new contacts. This employee as well as many others profited by the plan.

OPPORTUNITIES ON EVERY HAND

The following are only a few examples of a nurse's function in an industrial health program:

Three employees from the same department made frequent trips to the first-aid station asking for headache medicine. A review of their personal record cards indicated normal health and habits. A trip to the department revealed inadequate and glaring lights. A proper survey not only corrected the condition from a physical standpoint but likewise increased production to such an extent that a similar survey was made throughout the plant.

The use of corners by employees as a place to expectorate was effectively solved by painting white triangular areas in the corners and providing convenient cuspidors.

A high incidence of indigestion, nausea, and fatigue is often traceable to improper ventilation, suggesting the need of proper air-conditioning or protective equipment to eliminate this hazard.

SELLING THE IDEA TO MANAGEMENT

It is quite true that such a program presents a real problem in selling the idea of sickness prevention to executives—but patience and frequent reference to the time lost through sickness will eventually bring results.

How frequently and to what extent sickness among employees is a factor in causing lost-time accidents is often revealed when a thorough investigation is made of all incidents leading up to the accident. Such facts properly presented enable one to improve plant conditions so as to bring about better health.

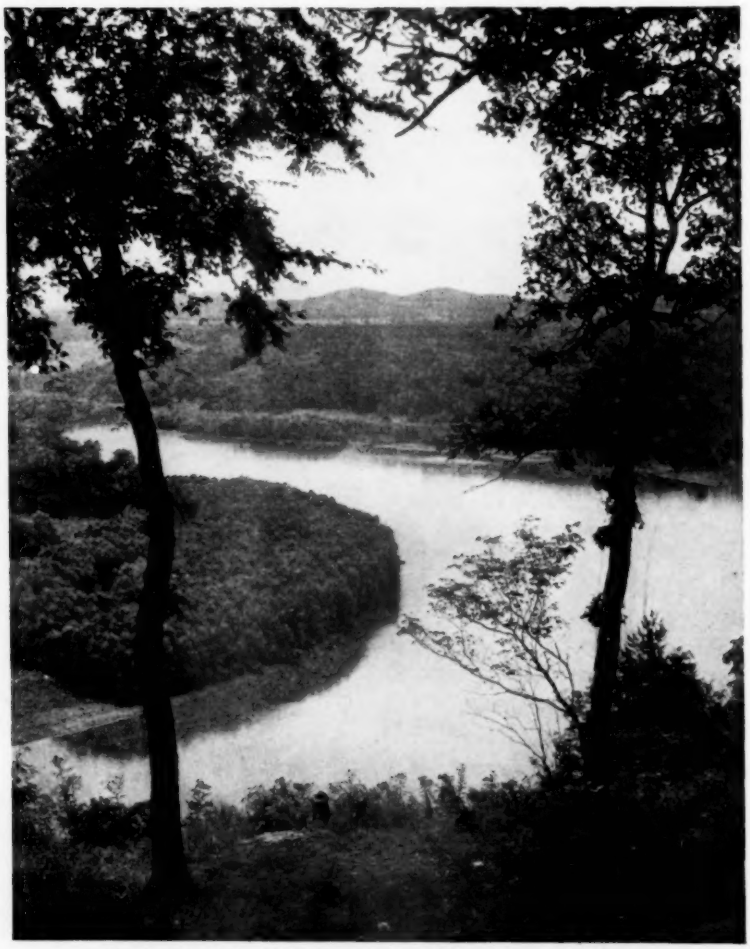
A considerable part of the sickness prevention program is education. Few employees, for example, realize that they have more leisure time than they have ever had before. The employee should be taught to use this with discretion. Today we practically have a national 40-hour work week, and allowing at least 56 hours for sleep, we find the employee has 72 hours left out of every week to use as he wishes.

Does he spend his idle time disastrously, thus adding fatigue to an already fatigued body? To safeguard against this it is well worth while to afford him recreational facilities, stimulating in him a desire for hobbies, home

ownership, or any other activities that may enable him to spend his time more profitably.

A definite program of talks and discussions on better health may be profitably planned during the winter months. The National Safety Council and leading insurance companies can provide excellent material for these discussions. State and national health departments are glad to furnish valuable information free of charge. Local physicians are pleased to talk to the employees on sickness prevention. A wide variety of resources are available, including local, state, and national health agencies.

Presented before the Industrial Nursing Section, National Safety Congress, Kansas City, Missouri, October 13, 1937.



Overlooking Lake Taneycomo—one of Missouri's popular resorts

What Can the Layman Do?

By HAL H. GRISWOLD
President, The Welfare Federation of Cleveland, Ohio

The layman's responsibility for meeting the problems of social adjustment is discussed in this article—which applies to the public health field as well as to social work

WHAT CAN the layman do in the process of adjusting the human element of modern life to the changes in physical conditions brought about by scientific inventions and discoveries and the industrial revolution? What the layman can do and what he will do will depend very largely on his ideas of what needs to be done. If he can be brought to see the task in its true proportions, there is little doubt of his ability and willingness to do it.

Great progress has been made in the past two decades. I am convinced that when the historian of two hundred years hence makes his analysis of what is happening now he will point to the decades which saw the development of the community chest movement as marking the beginning of an epoch, and the community chest as one of the significant characteristics of the time. Looking backward we see great accomplishment by the layman, and looking forward we have every reason to believe that what is past is but a beginning.

COMPLEXITY OF TODAY'S SOCIAL NEEDS

Since social work is based on the science of human relationships and deals with the relation of individual to individual, of individual to group, of group to group, and of both to the environment in which they exist, the layman will need to have some idea of the rate of increase in complexity of the social problem. If some engineer with a flair for social work could devise a coefficient that would express in numerical terms the complexity of 1937 society in terms of the year 1900 as a base, and if 1900 were represented by the index number 100, I have a suspicion that the year in which we live might be rated at 1000 or 2000 or perhaps 5000.

Let us take something tangible as a basis of thought. The automobile is perhaps symbolical of the spirit of today, representing as it does speed, power, and precision. The triumph in automotive engineering that brought forth the last model streamlined speedster was not primarily a feat of inventing mechanical gadgets or even in perfecting the more fundamental mechanical structure. Primarily it was a triumph in the selection, preparation, and fabrication of materials, and the fitting of special materials to special uses. The one-horse shay may have lasted one-hundred years, but an automobile built out of the same material, used in the same way, would not last one hundred minutes under the hammering of the speed of today's traffic.

The other triumph was probably in the improvement of lubrication. The hundreds of moving parts of the modern motor car fitted to hundredths and thousandths and even ten-thousandths of an inch, would burn themselves out in the first half mile without the correct type of lubrication.

These two ideas may be applied by analogy to the problem of creating a social organization fitted for the age of the automobile. With life speeded up physically, mentally, and emotionally,

and with people brought into ever closer contact and more numerous relationships, a constantly better type of social lubrication will be required. Certainly the human material for a social organization must be as carefully prepared and as painstakingly fitted to its special purposes as the materials of the streamlined roadster.

This new approach will cost money and the layman will be reluctant to furnish it unless he is convinced of its need. But if the problem can be made real enough to him, if the demand for improvement comes from him rather than from those who are doing the work at public expense, the layman will not hesitate to pay the price. He knows that the cost of a single filling of oil for his roadster would buy enough mica axle grease to lubricate the old farm wagon for many years and yet he willingly pays this cost.

LAYMAN'S PART NOT SECONDARY

With this conception of the size of the task, what can the layman do? Perhaps the question seems to imply that the layman's part is to be performed from the side lines, that his contribution is a minor or secondary one. This assumption is erroneous. The problem of social adjustment is the layman's problem. He can neither dodge nor delegate the responsibility although he will need to call in the services of an expert to care for the procedure.

It is, therefore, necessary that some very clear thinking be done as to the relation between the layman and the professional social worker. Like other problems, the social problem needs a scientific approach and such an approach can only be made by someone with special training and special aptitudes for it. But the lay worker need not develop an inferiority complex because the social worker knows more about this problem than he does, any more than he feels inferior when he employs an architect, because the architect has special knowledge about style and material and costs. The architect is still the servant, not the boss, and his employer is still able to decide for himself whether it is a mansion or a dog-house which he wants to have built. The professional worker will stimulate and counsel and coöperate, but progress will be made only when the conclusion that it is necessary is the layman's own. This relationship between the layman and the professional must be a two-way relationship, for each has something to give and something to receive from the other.

What the layman can do will depend also upon what equipment he has and what he can be given. We are prone to speak of the layman as though he were in a class by himself. But the kind of layman who will make a really significant contribution to the social problem is usually an expert in some other field. He is earning a living or building a business in an amazingly complex social and economic order. He is living in a highly competitive world where in order to survive he may need to "know more and more about less and less." If we are to get any significant contribution in time, money, and energy from him, we must bring the social problem within the field of his vision—not as something that intrudes from the outside but as something that very deeply concerns him and his special field. For many a business has been wrecked by some unanticipated change of social custom or relationship. Whether he is working with mechanics, or accountancy, or law, or something else, the relationship between human beings with which he has to work is becoming more and more a necessary element in his thinking.

Those who would educate the layman to an appreciation of social values must start where he is. If we could throw upon a picture screen something that would represent the thought of the average man when he hears the phrase "social work," it would approximate the

picture entitled, "Sweet Charity," given as a premium years ago by a popular magazine. We hope this spirit may always be present as an element in social work, but we must recognize that it should progressively yield to the preventive and creative idea. Most of us, although we know better, are likely to think of social work as entirely a matter of helping the unfortunate, rubbing salve on the social sores, and binding up the wounds of the victims of society.

You say the layman knows better. Yes, of course, he does know better intellectually when he stops to think. But we shall miss the point entirely if we fail to realize that except for his special field and interests, most of his thinking is of the traditional type and the impressions he received in his youth are more potent than what he learns later. Progress in social work consists in developing a method of social thinking. We must distinguish sharply between thoughts as such on the one hand and methods of thinking on the other. Our thoughts change with kaleidoscopic rapidity, but our method of thinking in any field is likely to remain fairly constant.

I think, therefore, it will be necessary to take a page from the book of the radio advertiser. We are told that the average radio program is based on a twelve-year-old mental level. The estimate is fairly accurate, not because we all have twelve-year-old intellects but because most of us, when we are thinking outside of the field of our special interests, are likely to use our minds at a twelve-year-old speed. As the complexity of life increases, and we are confronted with the necessity of choice of alternatives—whether of business investment, hair lotion, or social institutions—the tendency is to seek some easy criterion of judgment. In this state of mind, the emotions and wishes and size of the type in which the slogan is printed have more to do with choice than does the intellect.

If the layman is to understand the implications of the social conditions of today, the basic concepts must be reduced to language as simple as that of the radio. But in doing this, the professional will need to be careful that the social philosophy propounded is sound at the heart, because the adult intellect may awake sometime when we least expect it. And if it finds that the philosophy of its professional advisor is unsound, there is disaster ahead.

THINGS THE LAYMAN SHOULD KNOW

Certain fundamental concepts must be made a part of the traditional thinking of the layman. When I state these concepts you will probably say they are glittering generalities and that they are perfectly obvious, but we must remember that it is sometimes necessary to live with the obvious for a long time before we actually notice it.

1. The first concept is that of the organic nature of society. For society is not only organized; it is in every sense of the word an organism. It is undergoing a progressive specialization of functions with the creation of special functional organs to perform them. It has a circulatory system, the rapidity of whose circulation is increasing at a phenomenal rate. This means an increasing interdependence of functional parts. We used to scoff at the doctor who pulled a tooth to cure a pain in the knee. But today the idea underlying that procedure is almost universally accepted. Just as there is no part of the human body that is safe when infection exists in another part, there is no part of the social body that can remain unconcerned if disease, immorality, delinquency, and crime are allowed to develop at some other point.

2. The second basic idea which the layman must grasp is that social effects tend to lag far behind the causes that produce them. We have not yet and we will not for several decades feel the full social effect of the economic collapse of

the past six years. Any program for the future which the layman or professional person may conceive which does not make provision for this hangover from the past will prove as meaningless as a plan for financial reorganization of a corporation, that omits the debts.

3. Third, there is danger that in the age of mass production, the layman may get the idea that human relationships may be dealt with in that way, too. He must come to know that, for the most part, the social problem is an individual problem. Each member of society finds himself the converging point of a tremendous number of forces both within and without that will determine his future. Unpredictable human nature makes every such equation of forces a different one. This thought leads us to another. Confronted with a series of stresses and strains in the engineering or financial world as complex as those that operate on the individual in society, the business man calls in the engineer or the economist. Expert service has become one of the foundation stones of successful business procedure, and it must become a foundation stone on which an intelligent social order can be built.

Given the proper idea of the size of the task ahead, equipped with the fundamental ideas that must underlie an intelligent social program, the layman looks around for some point of application for his energies. The infinite variety of relationships dealt with under the general heading of social work makes it apparent that the approach to the social problem must be one of tremendous variety.

MOTIVES FOR VOLUNTEER SERVICE

There are many motives that impel lay volunteers to offer services. In some it may be a real and intelligent interest. It may be an emotional or sentimental motive. Perhaps in some it is a seeking for social prestige, and cases have been known where business contacts were hoped for. In some cases, no doubt, it is an outlet for pure boredom. Whatever the motive, surely the tasks which need to be done are so many and various that there is almost no type of ability which cannot be used, and it is not safe to cast aside an offer merely because the motive may be in question. There is in almost any human being a latent social interest. Those who "come to scoff may remain to pray." Whether the task of social organization is to be done by government or by private philanthropy or—as I believe—by both, success will require a broad public understanding. And in building this, numbers are important. In government it is votes that count, and in private philanthropy there is need for a constant broadening of the base of contribution. Moreover, the participation of the smaller givers is likely to result in making of large givers larger givers.

This does not mean that contact with mere numbers of laymen should be the standard, nor should volunteer work be looked upon as merely keeping somebody busy. Unless the volunteer can have a feeling that his work is significant, he may prove to be a liability instead of an asset. If the volunteer worker can be made to feel that what he is doing is part of a process that is agelong in its development and worldwide in its implications, then such recognition will lend dignity and meaning to almost any task.

In an attempt to clarify thinking, I wrote to the executives of twenty of the larger agencies of Cleveland, asking for suggestions as to examples of effective lay participation. The replies I received were rich in significant material. One note appears in all of them—that lay participation in the activities of social agencies is one of the most effective means for interpretation of the social problem to the public. And this is clearly true, for while there are some unusual individuals who can read a book or attend a lecture and develop a keen sense of social values, most of us need

to get the feel of the process by doing it, in the same way we do in learning to drive an automobile.

In choosing the channel for his efforts, the average layman has very little guidance. For the most part it is accident, not choice. But it is well to keep in mind the different types of participation, and to be able to explain clearly the implications of each to the prospective lay volunteer. He may participate effectively by merely speeding up his activities as a voter. He may seek public office or accept membership on advisory boards in connection with tax-supported public agencies. He may be a member of managing committees or boards of private agencies or actually participate in the program. Some intelligent means should be devised to help him weigh his interests and capacities in making the choice. In Cleveland, Ohio, a volunteer department has recently been added to the Welfare Federation staff and already gives great promise. This department grew out of a volunteer association which had proved its worth.

TREND TOWARD SUPPORT BY TAXATION

The most significant factor in the whole movement toward the development of a social program is the drift toward support from taxation. This is probably a natural and inevitable drift. Education was once a purely private matter. Then it became the responsibility of the church and of private philanthropy. Finally, the public offered it to those who would take it, and from there we progressed to the point where youth was compelled to take it whether they wanted it or not. At some time in every such development of human institutions, they reach the point where the sovereign power of the state must be called in not only to finance the activity but at times to compel its beneficiaries to accept it.

Undoubtedly the same trend will continue in the field of social work. Therefore every citizen in a real sense will become a volunteer if he exercises his privileges as a citizen at all. But the citizen who has social vision and wants to make it effective in government is troubled to find a way. Many feel they have done their duty when they have voted, and to many the task of influencing legislation consists in letters and telegrams to their senator and representatives. But these simple measures will not meet the needs of the day. Those who wish to influence governmental action in the development of an intelligent social program need to learn that the law of inverse squares applies to personal relationships as well as to gravity. The influence which you may exert on a public official is usually inversely proportional to the square of the distance between you and him. A personal conference with an official who knows you and has confidence in you, is worth more than all the telegrams that can be sent. And remember, "Men must be taught as though you taught them not and things unknown proposed as things forgot."

Probably the most effective influence which the socially minded people of this country have exercised on government has been through the coördination of the efforts and activities of private and public social agencies.

THE BOARD MEMBER

The service of laymen on managing boards and advisory committees is a field which cannot be treated in anything less than a volume. In order to be effective, the member of an agency board or committee not only must be willing to give his time and efforts to the current business of the agency, but he must know something of its history, its traditions, and its national connections. And above all, he must be able to see its work in relation to the larger social movements of his community. Recognition of the social problems of a community as a whole and the necessity for

close coöperation among agencies in any particular field and among the different fields of social work is increasingly a condition of maximum effectiveness.

Of course, loyalty cannot be spread over too large an area without destroying itself. Each agency arose out of the realization on the part of some individual or individuals of a need in a particular field. It began its work at a time when it had to work alone. It built traditions peculiar to the agency, peculiar to the community, and reflecting to some extent the personalities of its founders. Individuality in an agency should be preserved with the same degree of care as the individuality of a person, and the task of balancing this loyalty to an individual agency against the broader conceptions of social service may at times be an extremely delicate one. But if the needs of both are kept clearly in mind, a point of maximum operating efficiency of the two forces can be found.

NOT A RUBBER STAMP

Two observations should be made on this subject of managing boards. A managing board or an advisory board can be a success or a failure because of the manner in which it is used or permits itself to be used by an executive. Serving on many boards at different times, I have often wondered whether I was anything more than a rubber stamp, and whether—if I was not—it was my fault or the fault of someone else. I do not believe that any layman should allow himself to be a member of a board if he does not know enough about the subject matter of the agency's work to precipitate an occasional controversy. Predigested dockets and statements of policy so framed as to leave the layman with no chance to feel that the conclusions are his own have done much to dampen the enthusiasm of the layman for his work and leave his latent abilities still latent.

Again, the success or failure of a board or committee may be determined by the technique of getting people on it and getting them off. Too often, a board membership is looked upon simply as a parking place. Very often it is difficult to bring in new blood with new ideas because of the feeling that some of the older members may be offended if their membership is not renewed. In our city, we have been seriously considering a policy of automatic retirement of board members after a fixed period of service. Whether or not this policy is adopted or proves to be advantageous if adopted, we are convinced it is worth serious consideration.

ACTUAL PARTICIPATION

Last but not least in importance is the place of the lay worker in the actual program of the agency, where contacts are made with the human beings for which all this machinery is maintained and operated. I am personally convinced that the *point of operation* is the place at which there must be generated the great bulk of sound social thinking in the community, for it is only by this personal contact that the great majority of persons can visualize social values. But when one tries to discuss the subject logically he finds himself baffled, not by the scarcity of the material but by its volume and variety. The degree to which volunteers may be used in the program varies so widely with different agencies, with different executives, and with different communities, that general principles are difficult to state.

Five essentials in such a program seem to be accepted:

1. The use of the maximum number of volunteers which can be utilized constructively.
2. The use of the volunteer in activities which he can consider worth while.
3. The diligent search for special skills and aptitudes and for places to employ them.
4. Some centralized system of coördination and clearance of volunteer effort.
5. A definite program of training and instruction, formal or informal, for all lay

participants.* It should not be necessary for a layman to attend board meetings for a year before he knows what it is all about. A well planned friendly two-hour chat with a new board member, which is not too obviously a lesson, will work wonders. And the more this chat can take the form of seeking ideas from the new member, the more educational it will be to both.

THE TRAINING OF VOLUNTEERS

The education for participation in a program should not be an attempt to make a social worker out of a volunteer. A person may be taught the correct and effective use of an automobile without being made a mechanic. Probably the instructor can be of no greater help to a student driver than to teach him to adjust the carburetor—unless to teach him to let it alone and consult an expert. In social work as in other fields "a little knowledge is a dangerous thing."

In searching through the material submitted by executives of Cleveland agencies for suggestions regarding methods by which volunteer service might be used, I found many which seemed to give evidence of sound social thinking and which have proved their effectiveness. I also found that each was keyed in some peculiar way to the traditions, the personalities, and the policies of the agency adopting it.

Out of this study came the conviction that any agency with an executive and a board who have the broad community type of thinking, any agency with a thorough conviction that there is a place for the volunteer and a means in its organization for centralizing thought upon the problem will not be troubled by a lack of ideas as to what a volunteer may do. Its problem will be a lack of volunteers available to do the task. I also came to the conviction that a program of volunteer work that did not reflect and embody the traditions of the agencies, the personalities of its workers, and the spirit of the community would not succeed.

To summarize, the problem of social adjustment is the layman's problem, and if I read the signs correctly, the layman is becoming increasingly aware of that fact. In the newspapers, in the programs of our service clubs and civic organizations, in the record of achievements of our community chests, and in the talk of the man on the street, there appears to be an increasing concern about the problems of delinquency, and crime; about the impairment of human morale by recent experiences with relief, about the soundness of our methods of care and training of children, and about a thousand other problems that are the subject matter of daily discussion in our social agencies.

The task of enlisting lay efforts in the process of social adjustment is not a task of creating something new, but rather a task of developing latent powers, of drawing upon hitherto untouched reserves of social understanding that lie ready to crystallize themselves around clear-cut statements of principles. It is not a question of opposing one class which we may call socially minded against another class which we may accuse of selfishness and materialism. It is rather a question of diverting some of the farseeing vision, the organizing ability, and the spirit of the fearless pioneer from the task of building an industrial and economic system to the task of helping to build a social system fitted to go with it. Perhaps we shall find how often we call on the same individuals for the two tasks.

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*Davis, Evelyn K. "A Training Course for Volunteers in the Public Health Nursing Field." PUBLIC HEALTH NURSING, December 1937. "A Study of Volunteer Services." PUBLIC HEALTH NURSING, January 1938.

Presented before the National Committee of Volunteers in Social Work, Indianapolis, Indiana, May 26, 1937. Excerpts of this paper were published in the *News Bulletin*, Community Chests and Councils, June 1937. Published here in part only.

The Prevention of Home Accidents

By JOHN MELPOLDER
Consultant on Accident Prevention, American National Red Cross

The public health nurse has long been intimately associated with the family life of the nation. Yet the home remains the place of greatest accident hazard

EVERY CONSIDERATION that has brought public health nursing into being for disease prevention applies with equal force to accident prevention. For what are the comparative facts about accident and disease fatalities? Only four diseases kill more people than are killed by accident—heart disease, cancer, pneumonia, and nephritis. Among males only one disease kills more than are killed by accident—heart disease. Among females, six diseases. For children from one to four years of age, pneumonia comes first, accidents second. Among both boys and girls from five to nineteen years of age, accidents constitute the leading cause of death. Comparative facts on permanent disability caused by accident and disease would probably be equally revealing. In the face of these appalling accident facts, is there any reason why the nursing profession should not become as active in accident prevention as it is in disease prevention?

It would seem, however, that the profession has been a greater potential than actual force in this cause. The public health nursing profession is intimately associated with the family life of the nation. Yet more accidents occur and more people are injured, maimed, and killed by accident at home than on the highway, in other public places, or in industry. Moreover, the annual toll of home accidents is constantly increasing, while that of other types of accident is decreasing. The safety movement had its inception in industry, and its subsequent development chiefly in highway transportation. But the organized health forces have not taken the initiative and assumed leadership in the movement, nor formulated activity programs for accident prevention.

The public health nurse often attends injured persons in their homes, and no doubt she takes advantage of such circumstances to suggest to family members how essential it is to exercise due caution against accident. But a much more effective service could be rendered by her in accident prevention, such as that which she gives in disease prevention. This, however, is possible only when she is keenly sensitized to potential accident hazards in the home environment. In a scarlet fever epidemic she does not wait until members of families are stricken down before she instructs them in precautions to be taken to prevent the spread of contagion. She is well versed in disease precautions, but how lively an awareness has she of accident precautions? After all, accident is as dangerous to human life and well-being as disease. Its victims suffer as much if not more. They need as much nursing care. When killed they are just as serious a loss to their families and to society as if they had died of disease. The end results are the same. So it would seem that a public health nurse actually attains only half of her profession's humanitarian objective when she centers her attention on microbe hazards to the exclusion of equally fatal accident hazards.

Safety education is in its infancy, and we are still learning what is the most

effective way to teach accident prevention. "One recipe," says an educational authority, "should give us safety attitudes, another should aim at safety habits, and an entirely different recipe is clearly indicated if we are going to produce safety information as the major product of the lesson."* I don't know why we behave as we do. I refuse, however, to resort to a blanket disposal of all accident causes by ascribing them to human carelessness. I realize that back of many of them lie causes reaching deep into the hidden recesses of human conduct. Long established customs and traditions, habits and attitudes, are involved. So are physical and mental infirmities and weaknesses, fatigue, frayed nerves, and dulled reflexes.

HAZARDS OF THE MODERN HOME

Then, too, there are those who do not possess the required mental alertness and manual skill to make safe uses of our modern inventions. "Homes have become miniature production units," says E. George Payne, editor of *The Journal of Educational Sociology,* "with every conceivable gadget designed to lighten the burden of the housewife . . . We have not learned to use these tools of progress without disaster to ourselves. The instruments of progress, of ease, and of comfort have therefore turned out to be the deepest concern of our current civilization."

POPULAR EDUCATION

A complete safety program includes the three E's—enforcement, engineering, education. The American Red Cross participates in the accident prevention movement exclusively as a non-technical promoter of popular education. Moreover, it confines its activities specifically to the home and farm phases of the accident problem. Its efforts seek

Do not stand in a tub of water and switch on the electric light. Water is a conductor of electricity

to attain four simple objectives involving the recognition of common hazards:

1. Helping people to *see* existing accident hazards in their environment and activities.
2. Inducing them to *eliminate* these hazards wherever and whenever it is possible for them to do so.
3. Cautioning them to *safeguard* themselves and others against hazards that cannot be eliminated by them—that are beyond their authority and control to remove.
4. Above all, inducing them to prevent the *creating* of such hazards anywhere—at home, at work, at play, on the highway, and in other public places.

The Red Cross endeavors to inculcate a sense of moral responsibility for creating accident hazards where the deterrent of legal liability has little or no application. After all, a man's home is his private castle. When building code regulations have been complied with, neither legal authority nor social pressure can compel him to put a screen in front of his open fireplace, keep obstacles off of his stairsteps, open cans with a can opener, keep matches, poisons, and sharp instruments away from his children, take a bath without touching electric light fixtures, and to follow many other

*Rich, Stephen G. "Education in Safety or Safety in Education." (Editorial) *The Journal of Educational Sociology,* September 1937, p. 4.

precautions that must be observed if home accidents are to be avoided.

It is the nurse's experience as a teacher that so eminently qualifies her to give instruction in the practical phases of home accident prevention.

GROUP DISCUSSION

In recognition of the valuable aid that group discussion may bring to the cause of home accident prevention, the Red Cross issued in 1936 a seventy-nine page publication, "Lecture and Group Discussion Course on Home and Farm Accident Prevention," (ARC 1027). A copy is available to each instructor in home hygiene and care of the sick. It provides discussion outlines for six sessions with an appendix of statistical compilations and newspaper case stories pertinent to each topic. This group discussion course not only provides opportunity for the self-expression of the participants, but also helps in discovering practical ways and means for groups to engage in accident prevention activities in their homes and on their farms. It may be conducted with groups specially organized for this course, or as a preliminary or supplementary course in home hygiene or first aid classes. A plan is contemplated to develop this group discussion course into more formal study courses—one in home accident prevention and another in farm accident prevention—and to prepare elementary textbooks for these courses.

The accident prevention cause, however, is handicapped by the confusion between preventive and curative treatment. The terms *accident prevention* and *first aid* are indiscriminately interchanged even by professional people. To be sure, accident prevention has less emotional appeal than first aid. An accident prevented is no accident at all. It has no bruised and broken victims to display. It makes no appeal to compassion. Emergency first aid has such an appeal. The most that can be credited to first aid in accident prevention, however, is that the accident is used as a practical example of what happens when safety precautions are ignored. But 111,000 people were killed by accident in the United States in 1936, and 400,000 were permanently disabled. Despite this number of examples, the accident incidence is not abating. The accident problem is too serious a problem, accident prevention too vital to human well-being, to teach it as merely

Children should be taught that playthings are to be put away where no one will fall over them—not left on floors or stairways after use

Keep medicine cabinets locked or out of the reach of children. Lye, denatured alcohol, and other inflammable or poisonous things also should be out of reach or under lock and key

incidental to something else. Hence, the organization of groups and classes for instruction in accident prevention as apart from first aid has a definite value.

Other Red Cross efforts to attain its four objectives in accident prevention are: the organization of community accident-prevention committees, annual home and farm self-inspection campaigns, general accident-prevention publicity, and special publicity on seasonal hazards. For three years now the Red Cross annual self-inspection campaign against home and farm accident hazards has been conducted. Millions of checklists have been distributed to homes and farms with the aid of school teachers and pupils. More than 1700 local Red Cross chapters have conducted these campaigns and developed general community interest in the accident problem. Various types of community organizations have been drawn into service. However, group discussion promises to be the most effective method of stimulating continuing interest and activity. The fact that many nurses have requested copies of the group discussion course would seem to indicate a lively desire to participate in the cause of accident prevention.

Special attention of the public health nursing profession is called to a leaflet published by the National Safety Council, entitled "Hurt at Home,"* reporting on a survey of the causes and results of home accidents for which 4602 persons were treated at Cook County Hospital, Chicago, Illinois.

Although approximate figures in regard to the number of deaths and injuries in the nation resulting from home accidents had previously been available, more detailed and specific information was not obtainable. When the possibility of a study of home accidents resulting in hospitalization was suggested as a government relief project, the National Safety Council encouraged the plan.

Detailed reports were obtained regarding "4602 persons who were injured in home accidents during 1933 or 1934 to such an extent that hospitalization seemed advisable. Of this total, 286 persons died, 20 were totally disabled for life, 348 were partially disabled, and 3948 suffered disability lasting from a few days to several months. The total hospitalization given to these people amounted to 59,885 days, or 13 days per case. The aggregate cost to the

*Rupp, Francis, and Battey, Alvan D. Hurt at Home. Reprinted from *Public Safety*, National Safety Council, Chicago, August and September 1936. 11pp.

taxpayer of Cook County was $150,000."

It is pointed out in the report that there were certain limitations to the study. Since only patients who cannot pay for care at a private hospital are eligible for care at Cook County Hospital, the families covered by the study are in the lowest income groups. Moreover, since the study includes only injuries requiring hospitalization, "the distribution of cases by type of accident and age of person injured is not the same as if the study also included minor cases. For example, cuts and scratches were recorded infrequently, although they are probably the most numerous of all types of home accidents."

The following analysis is made of the types of home accidents and the personal factors involved:

Types of Home Accidents	
Falls	2910
Burns, scalds, or explosions	391
Stepping on or striking against objects	298
Struck by falling or flying objects	191
Cuts or scratches	150
Handling, lifting, or carrying objects	149
Poisonings	127
All other types	386
All types	4602
Personal Factors Involved	
Poor judgment	1095
Child cases (0-4 yrs.) charged to adults	451
Physical frailty due to illness and old age	386
Hurry	286
Intoxication	207
Lack of knowledge	134
Physical handicap	132
All other personal factors	432
No personal factor	1479
Total	4602

Statistics are dry and impersonal to most of us. Nevertheless, when more than 38,500 death certificates were counted in 1936 by the bureaus of vital statistics, and classified under the category of home accidents, the home accident problem revealed itself in its stark and cruel reality. "There's no place like home"—for accidents. Adding to this mortality figure, the estimates made by the National Safety Council that 170,000 people were permanently disabled and 5,450,000 were temporarily disabled by home accidents in 1936, the home accident problem looms before us in its appalling magnitude.

Don't try to open tins with kitchen knives or other sharp implements. It means many hands gouged and infected from both knife and can

Surely, the public health nursing profession has a vitally important part to play in preventing and abating this needless suffering and loss in the home life of our nation. It is brought as a challenge to the attention of the profession.

NOTE: The pictures used to illustrate this article are through the courtesy of the American Red Cross.

A second article by Mr. Melpolder on common hazards in the home and the knowledge which the nurse should have to participate intelligently in the prevention of home accidents will appear in the March issue.

The "Commentator Magazine" has contributed to the N.O.P.H.N. the use of its back cover for the February issue for a statement entitled "The Public Health Nurse."

What the N.O.P.H.N. Means to Me

This is the essay by a nurse which won a life membership in the National Organization for Public Health Nursing

WHAT DOES the N.O.P.H.N. mean to me? You may as well ask me why I get homesick or why I enjoy nursing!

First of all, the mere fact that I belong to a National Organization whose major interest is in the profession I have chosen seems to create an attitude of loyalty—loyalty to my profession and its principles, loyalty to the people we serve, loyalty to other nurses. It makes me want to become a better nurse!

As a member of the N.O.P.H.N. I do not feel alone, even though I am the only nurse in my county and have had limited experience. When Miss Public Health Nurse from Maine shares her experiences with Miss Public Health Nurse from Texas, and these problems and accomplishments are available to me in Indiana, I find it worth while indeed. Just the knowledge that I am not alone, but a member of the huge N.O.P.H.N. family seems to help.

I especially appreciate the assistance the National Organization offers me as an individual. Problems do arise, situations do occur, when I need just the help the N.O.P.H.N. can give. For example, last month I realized my publicity program was slipping. However, just recognizing the need was not enough. I needed help! Recent copies of PUBLIC HEALTH NURSING were available, and the article "Public Health Nursing Is News!" (April 1937) made me more conscious of the help I needed. By referring to the N.O.P.H.N. bibliography, I not only received within a few days the information I needed but I found the material sent me was suggestive of other new ideas. More problems arose and more answers were needed! My conception of publicity became larger than ever before. The nurse who utilizes the opportunities offered by the N.O.P.H.N. has the joy of solving her own problems. The N.O.P.H.N. helps us to grow.

If the PUBLIC HEALTH NURSING magazine were the only function of the N.O.P.H.N., the organization would be worth while. We find here a never ending source of information, written in such a way that we want to read it. We have news about our organization and our nurses, new ideas about our work and the best ways of carrying them out, questions and answers to stimulate our thinking. The magazine, like the organization it represents, is practical. The suggestions it makes are within our reach. It is applicable to our needs. Our National Organization does not want us to become narrow in our views, so we are each month referred to certain articles in *The American Journal of Nursing*. We must not forget that ours is only one division of our profession.

What does the N.O.P.H.N. mean to me as a public health nurse? It helps me to form higher ideals, both as an individual and as a public health nurse. It gives me a keener appreciation of the efforts of my community in our program. It helps me assume the responsibility I should take in both our local and state programs. It helps me to grow. It gives me the joy of achievement and so encourages me to do my own thinking. Yes, it gives me a broader vision of my own small job.

The N.O.P.H.N. is really our own organization. We may get from it what we choose.

CLEO L. HARTER, R.N.
County Nurse, Starke County
Knox, Indiana

May Day in Indiana

By HOWARD B. METTEL, M.D.
Chief, Bureau of Maternal and Child Health, Indiana State Board of Health

Plans are already afoot for May Day child health programs. How one state developed a statewide program with local community leadership is described here

MAY DAY—National Child Health Day, is celebrated each year on the first day of May. It is the yearly focusing point for the purpose of calling to the attention of everyone the fact that in the health of its children and the protection of motherhood lies the future of the Nation. On that day, special efforts are made all over the country, through health programs, talks, the distribution of literature, and every known device, to rekindle the public interest in the problem of child health. Traditionally, May Day has belonged to the children. It is, therefore, fitting that it should be marked as a time to pause and consider the progress that has been made in the protection of child life, and to take cognizance of the next steps for the promotion of wholesome childhood.

In the State of Indiana last year, the Governor issued a proclamation in which he designated May 1 as Child Health Day, with the ensuing week observed as Child Health Week. In the proclamation the Governor urged that all organizations interested in the promotion and conservation of child health coöperate with the public health authorities to bring about a better understanding and a keener public interest in securing and preserving the physical vigor and good health of the children of the state.

May Day was observed by a concerted program to focus attention upon the health and welfare of infants, preschool children, and school children. And best of all, a day of pleasure for the child himself, teaching him through play to love the out-of-doors, and to enjoy fresh air, sunshine, and all the things that go into the making of health and happiness. The chief aim of the Indiana state program was the establishment of some kind of permanent health work in each county.

The improvement and extension of health services to all children have been brought about since the enactment of the Indiana Public Health Act and the Indiana State Welfare Act on May 16, 1936, through the close coöperation of all official and non-official health agencies throughout the state. The Bureau of Maternal and Child Health of the Indiana State Board of Health assumed the leadership in the statewide observance of May Day for 1937. Knowing that the personnel of organization for the program would determine to a large extent its possible success, every effort was made to bring into the preliminary organization leaders from all of the medical, health, civic, religious, educational, social, political, business, and other agencies in the state.

The chief of the Bureau of Maternal and Child Health of the State Board of Health was appointed state chairman for May Day by the director of the State Board of Health, at a statewide conference called early in March. Attending this conference were representatives of the following agencies and groups:

State Medical Association
County medical societies
State Dental Association
State Nurses' Association

State normal schools
County and city health departments
Full-time county health districts
Girl Scouts
Boy Scouts
4-H Clubs
Parent-teacher associations
Public libraries
Church federations
Merchants' associations
Service clubs
Hospitals
State Pediatric Association
Visiting nurse associations
School and county nurses
City and county school superintendents
University Medical Center
State Welfare Department
Council of Social Agencies
Radio stations
State Department of Public Instruction
State Publicity Bureau
American Red Cross
State Board of Public Safety
Bureaus of the State Board of Health
Newspaper associations

At this conference a general statewide plan was drawn up, to be followed out in all of the 92 counties of the state. The secretaries of the county medical societies were appointed temporary chairmen for the celebration, and they in turn were to hold small conferences in their own counties similar to the one for the entire state.

LOCAL CHAIRMEN APPOINTED

It was suggested that in the event a county medical society secretary could not serve as permanent May Day chairman for his county, he appoint from his group attending this conference some person who would be a leader, and who was capable of being permanent county chairman. In many counties the public health nurse was named permanent chairman, while in other instances the medical society secretary chose to take the lead. And often representatives of the parent-teacher association or the tuberculosis association were named to this place. Smaller committees, each with separate chairmen, were then formed in each county—one for newspaper publicity, another for public school programs, another for programs in the churches, and another for baby clinics and health conferences.

A packet containing the following material was mailed to the permanent chairman of each county, and also to all county public health nurses, secretaries of county and city tuberculosis associations, chairmen of the child health committees of local parent-teacher associations, and to all other persons writing in for suggestions for May Day programs:

Suggested outlines for celebration of May Day
The President's Proclamation
The Governor's Proclamation
Lists of available literature and films
Bibliography of health plays
Detailed instructions.

Approximately 2000 of these packets were sent out from the State Board of Health offices.

The State Department of Public Instruction—through the Chief of the Bureau of Physical and Health Education of the State Board of Health—circularized every school superintendent in Indiana, outlining the plans for May Day, and requesting their full coöperation in the program. The 495 newspapers in the state were furnished with special series of press bulletins on subjects relating to various phases of child health, and mats of the Governor's Proclamation, as well as one showing the state health director looking on while the Governor signed the Proclamation.

POINTS OF EMPHASIS

In order to assure community participation, each county health official was furnished a questionnaire asking for a survey of existing child health services in his county. From these reports the state chairman of the May Day program was able to make an appraisal of local health needs. For example, some counties reported extensive activity in school health examinations, with little or no emphasis on preschool or infant health. Some communities showed no activity in the prevention of communicable disease, while other communities reported this to be their only project.

Special emphasis was placed on

a well rounded dental health program. For two months prior to Child Health Week, special dental health courses for nurses were conducted at the University School of Dentistry, in coöperation with the dental program of the Bureau of Maternal and Child Health. Then, too, since early fall the Bureau had been conducting visual educational programs in the public and parochial schools throughout the state.

The temporary local chairmen were each furnished with a suggested outline for the formation and organization of plans for Child Health Week, together with suggestions in regard to the existing health needs in child health work in their respective counties. This not only afforded a stimulus to new developments in child health work, but also aroused interest in the permanent program of maternal and child health activities in the various counties throughout the state. This is evidenced by reports of a marked increase in the expansion of child health services throughout Indiana during the entire year.

Believing that the medium of advertising is an effective method of interpretation to the public, the Bureau stressed the value of requesting local merchants to have window displays, such as infants' and children's clothing and proper feeding apparatus for children. The public health nurses were furnished with several of the attractive Child Health Day posters prepared by the U. S. Children's Bureau, and in many cities these posters were used by the merchants as the center of large window displays.

Many speaking engagements were filled during the week by the staffs of the Bureau of Maternal and Child Health, the Bureau of Public Health Nursing, and the Bureau of Physical and Health Education of the State Board of Health. Several large poster displays were sent out for the week, and practically the entire library of motion picture films of the State Board of Health was scheduled for use in various parts of the state. The Bureau of Maternal and Child Health also provided many lecture programs through its "refresher" courses during the week. In many localities the county welfare departments coöperated with the medical and lay groups having charge of the programs.

The April issue of the *Monthly Bulletin* of the State Board of Health was devoted to special articles and pictures carrying May Day messages. *The Journal of the Indiana State Medical Association* was especially coöperative in the program, and published several editorials and detailed outlines of programs for the celebration. Three special news releases pertaining to child health were sent out from the offices of the Association during the week.

Much of the success of the program in Indiana is credited to the county public health nurses. Their untiring efforts and leadership in the programs for their local counties were of utmost assistance. The public health nurse who goes into the schools, the homes, and the community agencies, and who is a leader in many community activities, is highly respected by the people of her county. She is in position to evaluate the health services for her county, and to know the weak points of the health programs which need particular stress.

The state chairman considers that there was throughout the state last year a more general observance and a greater enthusiasm in Child Health Week, with a realization of its influence in stimulating action for the better safeguarding of children. It is believed that the program for improving public health, including that of the children, depends upon the constant and carefully planned information to the public, and that an increasing interest in Child Health Day marks a step in advance toward the goal set.

Uniforms Keep Up to Date

A STUDY was recently made by the National Organization for Public Health Nursing of the type of uniforms worn in a very small sampling of public health nursing agencies. It was found that these various agencies had uniforms adapted to their special needs in regard to climate and type of work.

Color

Although blue in various shades is the color most frequently worn, tan and gray are also used. (We have heard of one agency wearing green with brown accessories.)

Material

Some type of washable cotton is the material most frequently used. Broadcloth, seersucker, and dotted swiss are among the cotton materials reported. Silk is also popular, with flat silk crepe, Chinese pongee, shantung, silk linen, and sudanette among the materials selected. Wool is sometimes worn in winter; wool crepe and jersey were both reported as used.

Not a white uniform, but one of pongee silk worn by the nurses of the Visiting Nurse Association of Pasadena, California

Paul Parker Photo

The nurse in blue as she appears in the more conventional uniform of the Henry Street Visiting Nurse Service in New York

Style

The style varies with local agencies. Collars and cuffs of the same material as the dress are used by some, white by others. While ties are frequently worn, they are by no means universal; some organizations use the mannish tailored tie and some the Windsor tie.

Summer uniforms

There is a tendency to adapt the summer uniform to the comfort of the nurses. Many organizations use short sleeves in summer, and some the year round. Organizations tend to use lighter weight materials in the summer than in the winter, and some which wear stiff collars in the winter change to

either self-collars or soft white collars in summer.

Accessories

Departures from the usual blue or black coats and accessories are the dark brown coats, hats, shoes, and tie (if used) which are worn with the tan uniforms. Some organizations are using white shoes in the summer.

Source of supply

Some organizations have their uniforms made locally through a local supply house or tailor; others order from uniform supply houses.

This material on uniforms has been assembled in summary form, and more detailed information is available upon request from the N.O.P.H.N., 50 West 50 Street, New York, New York.

What Is the Merit System?

MISCONCEPTIONS which exist regarding the merit system and its relation to the civil service status are clarified in an article appearing under the above title in *The Compass*, official magazine of the American Association of Social Workers, in December 1937.* Excerpts from the article are reprinted here:

Merit system defined

The merit system (adopting a definition used recently in Pennsylvania) may be defined as: "a system of personnel management for the civilian employees of the government in which employment, compensation, promotion, demotion, and discharge are based upon merit and merit alone."

More specifically the merit system includes certain devices which have been found in practice to have value in handling the employment, compensation, promotion, demotion, and discharge of public employees.

Classification of positions

One device is the classification of positions, including the allocation on a logical basis of duties among various grades of positions, the formulation of the qualifications of education, training, experience, and personal traits which are required to perform the duties competently, and the determination of equitable compensation so that on the one hand the government does not waste its funds and on the other that it does not impair the morale of its employees by showing favoritism among them. Any particular political or religious affiliation or any particular place of residence should be excluded from the qualifications so determined.

Recruiting and testing

Another procedure of the merit system is ingenious recruiting of well qualified persons as candidates for positions.

Another is the testing of the qualifications of candidates so that only the best qualified for the position in question may be chosen.** Appointments should be considered provisional in nature until the person selected has shown his ability to perform the duties of the position during a probationary period.

Other procedures

Policies regarding advancement in salary, promotion, and demotion should

*The article in *The Compass* by William W. Burke, President of the Missouri Association for social welfare, is reprinted from *Building a Better Siate*, published by the Missouri Association for Social Welfare

**For a discussion of selecting and testing in public health nursing agencies see Personnel Policies in Public Health Nursing, by Marian G. Randall, The Macmillan Company, New York, 1937. $2.

be such as to give incentive to the employee to give good service.

Systematic effort should be made to train workers on the job so as to increase their value to the service, and to help them prepare for more responsible positions.

Tenure should depend on the acceptable performance of duties, not partisan political considerations. Workers unable to perform their duties acceptably should be resolutely separated from the service but only after their inadequacies have been brought to their attention and after definite efforts have been made to assist them to make good their deficiencies. It may be added that it is a mistake to suppose, as many frequently do, that inefficient employees are not removed under a well ordered civil service system; too often, due largely to public indifference, what has passed for civil service is not worthy of the name, either in regard to employment or discharge.

Finally, workers should not be subject to political assessments, and should be free to vote as their consciences dictate.

Such devices and procedures, if substantially in effect, constitute the merit system. Broadly speaking, if many of them are absent, the merit system does not prevail.

Merit system possible without civil service statute

It should be pointed out that, while such procedures may be required by statute, and while a civil service statute is of assistance in instituting them and in their effective functioning, such a statute is not indispensable to the merit system. The presence of a civil service statute does not necessarily produce a merit system because much depends on how the statute is administered. Most of these procedures (except to the extent that the use of some of them may be prohibited by existing laws) can be used by administrative authorities who wish to do so, and who are supported by public opinion, even in the absence of a civil service statute.

GUIDE POST FOR BOARD MEMBERS

The responsibility of the layman in bringing about social adjustments to meet the social needs of our time is forcefully discussed by the president of Cleveland's Welfare Federation. Page 89.

The industrial nurse's part in reducing preventable illness in industry is described on page 85.

The home as a place of accident hazard and the opportunities of the nurse to bring about reduction of these hazards are discussed on page 96.

How do you visualize the public health nurse—as a "lady in blue"? A report on page 105 shows that various organizations have different uniforms adapted to the needs of their own situations and local climatic requirements.

The prize-winning article on "What the N.O.P.H.N. Means to Me as a Public Health Nurse" is published on page 101.

The tentative program for the Biennial Convention appears on page 117.

The Washington Conference on Better Care for Mothers and Babies is reported on page 71.

Does your organization have problems in regard to the affiliation of students for field experience? Some questions on this subject which have come to the N.O.P.H.N. are discussed on page 72.

Is your organization doing its part in reducing preventable deaths from pneumonia? Page 74.

Minimum Qualifications for Nurses Appointed to School Nursing Positions

BETTER preparation for school nurses is being increasingly emphasized. More employers are demanding that their nurses have special preparation in public health nursing and higher educational qualifications as well as desirable personal qualifications.

In keeping with the nationwide trend for better preparation of all nurses the Education Committee of the National Organization for Public Health Nursing has outlined qualifications for public health nurses which it was felt could be generally met by 1940. While these qualifications apply specifically to new appointments to positions, the importance of additional preparation for those already appointed should not be minimized. It should also be recognized that these are only minimum qualifications, which have already been surpassed in many places.

For the convenience of employers of school nurses, the "Functions in Public Health Nursing"* and "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing"** prepared by the National Organization for Public Health Nursing are here excerpted and stated in brief form.

FUNCTIONS IN SCHOOL NURSING

The public health nurse in the school carries on the following functions:

1. Participates in formulating and developing a health education program based on the needs of the pupils.

2. Assists physicians in the examination of pupils and the interpretation of findings to teachers, parents, and children.

3. Teaches the value of adequate health supervision and facilities for medical and nursing care and assists in securing corrections of defects.

4. Encourages and instructs teachers, parents, and pupils to observe and recognize deviations from normal health.

5. Assists in the control of communicable diseases through teaching the recognition of early symptoms, the importance of isolation, and the value of immunization.

6. Contributes to the maintenance of a healthful school environment—physical, emotional, and social.

7. Arranges for the care of emergencies and minor injuries and illnesses in accordance with procedures having medical approval.

8. Participates in a program for the prevention of handicaps and the care and education of handicapped children.

9. Develops relationships to coördinate school nursing activities with all other health forces of school, home, and community and to promote community health resources.

10. Participates in curriculum making. Nurses who are qualified may instruct classes in principles of healthful living and care of the sick.

MINIMUM QUALIFICATIONS FOR NURSES APPOINTED TO SCHOOL NURSING POSITIONS

I. For the nurse in a school system or health department which provides supervision by a nurse who meets the qualifications set forth under III below:

Preparation:

a. General education—Graduation from an accredited high school is essential, and more advanced education on a college level is desirable.

b. Professional preparation:

1. Fundamental nursing education. The following are essential:

*PUBLIC HEALTH NURSING, November 1936.
**PUBLIC HEALTH NURSING, March 1936.

(*a*) Graduation from a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of 100 patients.

(*b*) Instruction and experience in the care of men, women, and children, including patients with communicable diseases.

2. Instruction and experience are desirable in the following:
   (*a*) Out-patient clinics
   (*b*) Psychiatric nursing
   (*c*) Public health nursing under a nurse supervisor who meets the qualifications set forth under III below

c. Registration for the current year under the nurse practice law of the state

d. Personal qualifications:
The following personal qualifications are of the utmost importance for a school nurse: an interest in and ability to work with children and adults; good physical health and emotional stability; initiative; good judgment; resourcefulness.

II. For the nurse in a school system or health department working without the guidance of a supervisor who meets the qualifications set forth under III below:
Preparation—*All* of the qualifications for a nurse working with supervision (See I above), and in addition the following:

a. Professional preparation:
Special preparation in public health nursing:

1. At least one academic year of study in public health nursing in one of the colleges whose program in public health nursing is approved by the National Organization for Public Health Nursing.
2. At least one year's experience under qualified nursing supervision in a public health nursing service in which family health service is emphasized. It is highly desirable that this experience include school nursing.

b. Personal qualifications—Ability in organizing the school nursing service in a community and a special aptitude for working with lay and professional groups.

III. Supervisory positions:

Supervisor—Since the supervisor of school nursing usually carries in addition to the usual supervisory duties the responsibility for the educational program for both new and old staff members and often for the field experience of undergraduate and post-graduate students, she should have the qualifications for both supervisory and educational work.
Preparation—*All* of the qualifications for a nurse working with and without supervision as set forth in I and II above and in addition the following:

a. Professional preparation:
1. A college degree, including courses in education, is essential.
2. Preparation in the theory and practice of supervision is desirable.
3. At least two years' experience under qualified nursing supervision in a public health nursing service.

b. Personal qualifications:
In addition to the qualifications listed for other school nursing positions, the supervisor particularly needs to have executive and teaching ability, and also vision and imagination in relation to the development of the program and to the potentialities of the individual nurse.

APPROVED COURSES IN PUBLIC HEALTH NURSING

(Further information regarding these courses and others that may be approved may be secured from the N.O.P.H.N.)

California—University of California, Berkeley
District of Columbia—Catholic University of America, Washington
Massachusetts—Simmons College, Boston
Michigan—University of Michigan, Ann Arbor
Wayne University, Detroit
Minnesota—University of Minnesota, Minneapolis
New York—Columbia University, New York
Fordham University, New York
University of Syracuse, Syracuse
Ohio—Western Reserve University, Cleveland
Oregon—University of Oregon, Portland
Pennsylvania—University of Pennsylvania, Philadelphia
Tennessee—George Peabody College for Teachers, Nashville
Vanderbilt University, Nashville
Virginia—Medical College of Virginia, Richmond (Negro)
School of Social Work and Public Health, Richmond
Washington—University of Washington, Seattle
Territory of Hawaii—University of Hawaii, Honolulu

Reprints are available free of charge from the N.O.P.H.N., 50 West 50 Street, New York, N. Y.

How Would You Answer These?

We are publishing here the answers to the January questions on maternity nursing (page 45), which were offered as a guide to analyzing the prize-winning paper published in the same issue (page 43). We are also publishing some comments on the prize-winning answer. Won't you send in your comments and suggestions—or better still, won't you send your answer to the question which was published in the May number (page 321), to the Maternity Center Association, 1 East 57 Street, New York, N. Y.?

1. *Starting with the number of visits per year, as given by the author, what distribution of nurses do you arrive at—assuming the average number of visits per nurse per year to be 2200?* Compare this with the author's distribution.*

Distribution of Nurses by Services

	Calculated distribution[1]	Author's distribution
Preschool and school	0	3
Morbidity	5	6
Maternity		
a. Antepartum	1 (approx.)	2
b. Delivery	.7	2
c. Postnatal	1 (approx.)	1

[1]On basis of total number of visits per year as indicated by author.

2. *On the basis of the total number of visits per day and the number of nurses for each service, as shown in the table, how many visits* per nurse *per day do you get for* each service? *From the table, is it possible to compare each of your figures with the author's results? What service is not provided for in this calculation?*

Visits per Nurse per Day

	Calculated number[1]	Author's results
Preschool and school	0	Not given
Morbidity	6.1	Not given
Maternity		
a. Antepartum	3.5	Not given
b. Delivery	.33	.33
c. Postnatal	6.6	6.6

[1]On basis of total number of visits per day and total number of nurses as indicated by author.

It is not possible to compare the preschool, morbidity, and antepartum figures with those of the author, because no figures are given for these services. (A combined figure of 3.9 for the morbidity and antepartum services is given in the author's results.) The preschool service is not provided for at all.

3. *Using the figures which you get in 2, how many visits per nurse per day do you get for the morbidity and antepartum services combined? Compare this with the author's result (3.9). Would the nurse have time left over for additional visits in other services?***

Visits per Nurse per Day

	Calculated number	Author's results
Morbidity	6.1	—
Antepartum	3.5	—
Combined	9.6	3.9

Allowing an average of 8 to 10 visits per day for each nurse, it is obvious from the calculated number (9.6) that the nurses assigned to these two services would have little, if any, time left over for additional visits in other services, such as the preschool service.

4. *How many visits per nurse per day do you get for delivery and postnatal services combined? (Multiply the number of delivery visits arrived at in question 2 above, by eight, before adding to the postnatal visits.*) Could the nurse make additional visits in other services?***

*For the delivery service, assume that the 200 delivery visits are equivalent to 1600 usual visits. (See "The Delivery Visit," PUBLIC HEALTH NURSING, April 1937, page 242.)

**An average of 8 to 10 visits per day for each nurse may be assumed.

Visits per Nurse per Day	
Delivery	2.64 (3.3x8)
Postnatal	6.6
Combined	9.24

Again allowing an average of 8 to 10 visits per day for each nurse, the nurses on these two services would have little, if any, time left for additional visits in other services.

5. *Would you conclude that the author of the prize-winning article apparently arrived at her distribution of nurses:*

a. By first analyzing the volume of service required on the basis of facts given, and then estimating the number of nurses required to meet those needs according to generally accepted standards? (See Community Health Organization *by Ira V. Hiscock, page 155)—or*

b. By first assuming a certain distribution of nurses between services and then dividing the volume of expected service between the nurses?

The prize-winning article uses procedure *b*. When the procedure is reversed and the number of nurses is estimated on the basis of the number of visits required in each field as in *a*, a different distribution is reached.

COMMENTS ON PRIZE-WINNING ARTICLE

Fourteen public health nurses in a town of 30,000 people should be able to staff a rather complete public health nursing program according to standards accepted today, since the ratio of nurses to population would be one to each 2143 people. This approaches the ratio of one public health nurse to 2000 people generally estimated as the minimum number required for a complete program.

If the writer of the prize-winning article intended to include under morbidity service the prevention and control of communicable disease as well as nursing care of the sick, and to include infants in the preschool service, she has listed all the public health nursing functions usually included in a complete community health program.

We know the birth rate to be 16.6 per 1000 population or about average, since the total births in one year numbered 500 in a population of 30,000. No other information on vital statistics is given but we do know that the citizens are in economically comfortable circumstances; hence the health conditions should tend to be good. It is therefore reasonable to assume that the morbidity and death rates are not above average.

On the basis of estimates given by Dr. Ira V. Hiscock in his book, *Community Health Organization,* the service of 14 public health nurses divided by type of work in an average town of 30,000 would be somewhat as follows:*

TABLE I

Estimated Amount of Nursing Service in Various Parts of Program

	Number of nurses
Communicable disease	1.
Venereal disease	.3
Tuberculosis	.5
Antepartum	.4
Delivery	.3[1]
Postpartum and newborn	1.
Infant care	.7
Preschool care	1.7
School care	2.5
Morbidity (non-communicable)	4.
Total	12.4

[1]This figure is based on service to 100 cases or one half of the home deliveries in the community, which is a reasonable number to expect. (The author has based her estimate on service to 200 cases, the total number of home deliveries in the community.) Also, Dr. Hiscock's estimate has been adjusted to allow for an average of 401 minutes for each delivery, the average determined by a recent N.O.P.H.N. study.

These, plus a director of nurses and half of the time of the 13th staff nurse given to supervision, make a total of ***14 nurses.***

*Hiscock, Ira V. Community Health Organization. The Commonwealth Fund, New York, 1932, p. 155.

TABLE II

Comparison of Author's Estimates with Estimates Based on Hiscock

Service	Number of nurses—based on Hiscock's estimates	Number of nurses—estimated by author
Morbidity (communicable and non-communicable disease)	5.8	6
Antepartum	.4	2
School, preschool, infant[1]	4.9	3
Delivery and postpartum	1.3	3
	12.4	14
Director and part-time supervisor	1.6	—
Total	14	14

[1]It is assumed that the author of the prize-winning article has included infant care, with the exception of the newborn, in her preschool and school service, since it is not listed separately.

The small number of deliveries would scarcely justify a specialized service. It would seem more efficient to carry the delivery service as a part of the generalized service instead of by the use of special nurses who also give postpartum care.

Although the prize-winning article has allowed five times as much time for antepartum care and twice as much for delivery and postpartum care as the estimates based on Dr. Hiscock's figures, there may be some justification for this emphasis in view of our maternal mortality statistics. Since the maternal mortality statistics for the hypothetical community are not given, the writer is apparently assuming that they are the same as those for the average community. R. H.

THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY

The Silent Members Speak

Figures, records, and reports come to life and dance like the famous wooden soldiers before our eyes in these humorous excerpts from *The Visiting Nurse*, Detroit, Michigan

EVERY HEALTH ORGANIZATION is responsible for reporting its activities to the community. In order that the Visiting Nurse Association may do so, our records must be accurate and well kept, for it is only through comparable figures that the value of our work can be determined.

In the following pages, the main office records department introduces itself, and in a humorous vein, explains its work and some of its problems.

FIGURATIVELY SPEAKING

The ten little digits and I occupy an office readily identified by its wee-ness, its Brobdingnagian cupboards, and its subnormal temperature.

Our work is in no sense spectacular.

On January second, from the mass of data which has accumulated during the year, we start assembling our part of the annual report which must be ready willy-nilly for the meeting at the end of the month. This meeting is the event of the year for us. Our board members, friends, and as many of the staff as there is room for come to hear all about the Association's accomplishments for the past year.

Then the digits and I go into a huddle to determine the cost of a field visit. In due time, after much activity, we emerge with a feeling that we are entitled to a medal. But wait! We have yet to obtain the approbation of the insurance companies with whom we have contracts for nursing service. Hopefully and prayerfully, we mail a copy to each company. But we learn very soon that we have set the rate too high.

Somewhat crestfallen, the digits and I again go into a huddle, taking the pruning shears with us. This time we bring forth a brain child reduced to a state of pernicious anemia. Again we send the copy to the insurance companies, and along about the time when vacations are in full swing, we receive the final word that we are agreed on the cost of a visit.

On September 1, the annual budget form is put on our desk. By the fifteenth this must be completed. While the year is only two-thirds gone we must somehow know how much money we are going to collect and spend during the year. With the knowledge that soup kitchens are closed, and bread lines relegated to the past, and with the many radio sermons telling us to have confidence in our government, it is our patriotic duty to be optimistic. So we confer with the board and Miss Sargent, (Director of Nurses), make the budget, and send it to the Community Fund. In just no time, we have a message from that office: "It can't be done."

With somewhat dampened spirits, we put our budget through the wringer and return it to the Community Fund. But when we get the final word about February 15, we find we are still too demanding.

Between times, the little digits and I are not just sitting on a log petting our dog. We have plenty of current chores, and engage in many skirmishes, such as bookkeeping, purchasing, automobile insurance, departmental costs, and monthly budgets. We are always on hand to meet the army who endeavors to earn a living by selling anything: pen points, automobiles, pedometers, envelopes, in-

surance, lubricating oil, adding machines, and what-is-its.

By December 31, I can honestly pronounce my benediction on these ten little digits. "Well done, good and faithful servants."

ETHEL JARDINE.

LIKE WORKING A PUZZLE

Monthly tabulated sheets, which are compiled from the dismissed patient records and the nurses' records, come into the main office from the substations on the third of each month. From these reports are compiled the reports which show the value of the various services—individual statements on the monthly case-load, the time spent, and the money expended.

Sometimes it's like working the . . . contest puzzles to make the figures mean what they say! But it's human nature to err occasionally, so the records are not always perfect.

The other day I found a nurse busy making tuberculosis visits; another, venereal disease visits. But no such patients were listed in their records. Another had a dead patient dismissed with a certain diagnosis, but no such diagnosis had been made. Sometimes I've known of patients to lose their color from one month to the next—but not from fright! One day a clerk said to me with a puzzled frown, "I've heard of all kinds of diagnosis, but never have I heard of *cat bile*." "Well," I said, "Cross the 'l' and make it 'bite' and I think you'll hit the nail on the head."

Some errors, of course, can be readily adjusted, but again sometimes we have to dig through a month's load of dismissed records to catch the mistake.

BELLE FRISKEY.

This interesting house organ of the Detroit Visiting Nurse Association was described in the November 1936 issue, page 742.

STATISTICAL DEPARTMENT

(OLD ENGLISH DIVISION)

These quaint classifications of causes of deaths are taken from the Bills of Mortality of the year 1665, covering the deaths in London for one week.

THE DISEASES AND CASUALTIES OF THIS WEEK

Abortive	5	Mother	1
Aged	36	Plague	2817
Apoplexic	1	Pleurisie	1
Childbed	25	Purples	2
Chrifomes	22	Quinsie	3
Consumption	130	Rickers	14
Convulsion	58	Rupture	3
Caugh	2	Scouring	3
Distracted	1	Scurvey	3
Dropsie	32	Spotted Feaver	174
Drowned in a Ditch at Saviors Southwark	1	Stillborn	11
Feaver	314	Stone	3
Flox and Small Pox	11	Stopping of the Stomach	10
Flux	1	Suddenly	2
Grief	3	Surfeit	85
Jaundies	2	Teeth	90
Imposthume	16	Thrush	4
Infants	13	Tiffick	3
Kingfurl	2	Ulcer	3
Leprosie	1	Vomiting	1
Meagrome	1	Worms	18

The New Yorker

Gleanings

This department is devoted to new ideas regarding improvised equipment, publicity programs, administrative problems, etc. Send us your contributions!

A PLANNED PROGRAM FOR HEALTH EDUCATION

An effective method for planning health education programs is found in a mimeographed calendar of suggested activities prepared by the Health Education Section of the Welfare Council of New York City. While this calendar has been prepared for the use of the local agencies in New York City, the idea is one which is adaptable for any community and offers an aid for community planning.

The calendar lists dates of important local health happenings and suggests health subjects which are of seasonal importance or are related to nationwide health education activities. It is not intended that educational campaigns be planned around all subjects nor that all agencies will have equal interest in all subjects which are selected for emphasis.

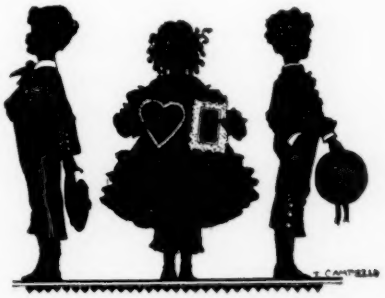
For each subject listed, information is provided as to its importance as a community health problem, including a few basic statistics on this problem and the special resources which are available in the city to meet it. It also announces any particular plans which any agency may have in relation to special problems.

The topics listed for December, January, and February are:

Colds
Syphilis and gonorrhea
Cancer
Diabetes
Heart diseases
Tuberculosis
Diphtheria immunization
Conservation of hearing
Conservation of sight
Nutrition
Health examination
Dental health
Pneumonia prevention and control

ANOTHER HOUSE ORGAN

Another visiting nurse association has found expression in a "house organ." The Visiting Nurse Association of Reading, Pennsylvania, sends out to staff and board members a little mimeographed booklet called the *VNA Digest*, prepared by members of the staff. We know the contributors must have profited as much in preparing the articles as the readers have enjoyed reading them. As the paper grows in age and stature, we hope it will publish also results of the staff's study of the association's own needs and problems. Why not make such a bulletin a joint project of staff and board? We congratulate the Reading, Pennsylvania, *VNA Digest* and wish it continued success.



NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

WITH THE STAFF

Because the Board meetings were held the latter part of January, most of the staff stayed at headquarters and very few field trips were made. On January 17 and 18, Dorothy Deming, Ruth Houlton, and Purcelle Peck attended the Conference on Better Care for Mothers and Babies held at the U. S. Children's Bureau, Washington, D. C. Ruth Houlton attended the meeting of the Advisory Council of the National Congress of Parents and Teachers at the Hotel Pennsylvania, New York City, on January 21. On January 4, Evelyn Davis was the guest speaker at a meeting of the Social Service Committee at the Roosevelt Hospital Nurses' Home, New York City. She spent January 10 and 11 in Boston, Mass., and the 12th in Providence, R. I., conferring with the visiting nurse associations on the program of volunteers. On January 6, Mrs. Anna Miller, our statistician, went to Amsterdam, New York, to observe the record system in the district health office of the State Department of Health, and on the 21st she visited the City Health Department in Baltimore for the same purpose.

HONOR ROLL

"Our staff of eight nurses sent in N.O.P.H.N. membership dues for 1938 last week. We are so glad to remind you that this makes us eligible for an Honor Roll Certificate, our fifth in as many years."

We're just as proud of this achievement as the writer! Their Honor Roll Certificate is now being displayed by that nursing staff as a reward for their continued loyalty and support of the N.O.P.H.N.—and we hope that more certificates than ever before will wend their way 'cross country in 1938.

Every nursing service—whether staffed by one nurse or one hundred—is eligible for Honor Roll listing and Certificate when each nurse has joined the N.O.P.H.N. for 1938. Don't forget to let us know just as soon as you are eligible.

In the March issue of PUBLIC HEALTH NURSING we shall publish a list of those who have already enrolled 100 percent strong. Remember—the Honor Roll list is not cumulative during the year, but each month in the magazine we will publish the names of those agencies whose staffs have attained Honor Roll standing since the previous list appeared.

Be among the "100 percenters" by making sure that each nurse on *your* staff joins the N.O.P.H.N.!

A WEDDING

Wedding bells mingled with Christmas bells in December when Lulu St. Clair was married on Christmas Eve to Victor John Perry Blaine. Miss St. Clair is the Executive Secretary of the Joint Committee on Community Nursing Service of the three national nursing organizations. She will continue her work under her own name.

BIENNIAL BUSINESS MEETING

The biennial business meeting of the N.O.P.H.N. will be held on Tuesday, April 26, at 11:00 a.m. in Kansas City, Mo., during the week of the Biennial Convention. Admission to this meeting will be *by N.O.P.H.N. 1938 membership card only*. So please be sure to bring your membership card with you.

TENTATIVE BIENNIAL CONVENTION PROGRAMS

KANSAS CITY, MISSOURI, APRIL 24-29

JOINT SESSIONS

All Joint General Sessions will be held in the Auditorium.

Monday: Opening Session, 8:30 P. M.
Presiding—Susan C. Francis, President, American Nurses' Association
Invocation—Rt. Reverend Monsignor James N. V. McKay, St. Peter's Rectory, Kansas City, Mo.
Welcome to delegates—Susan C. Francis
Greetings from the state—Clara Louise Wright, President, Missouri State Nurses' Association
Welcome to Kansas City—Mayor of Kansas City.
Award of the Walter Burns Saunders Memorial Medal
Address: The Nurse as a Member of Her Profession—Effie J. Taylor, Dean, School of Nursing, Yale University, New Haven, Conn.

Wednesday: 9:30 A. M.
Presiding—Amelia Grant, President, National Organization for Public Health Nursing
Announcements
Address: Problems Relating to the Merit System—May Kennedy, Associate Director, New York Hospital School of Nursing, New York, N. Y.
Discussion: Marian G. Randall, Supervisor of Records and Studies, Henry Street Visiting Nurse Service, New York, N. Y.
Address: To be announced

Thursday: 9:30 A. M.
Presiding—Amelia Grant, President, National Organization for Public Health Nursing
Address: Organizing for Better Community Nursing Service—C.-E. A. Winslow, Dr.P.H., School of Medicine, Yale University, New Haven, Conn.
Discussion: Grace L. Reid, Strong Memorial Hospital, The University of Rochester, Rochester, N. Y.
Address: To be announced

Thursday: 8:30 P. M.
Presiding—Nellie X. Hawkinson, President, National League of Nursing Education.
Invocation—Rev. George P. Baity, Westport Presbyterian Church, Kansas City, Mo.
Address: Subject to be announced. G. W. Frasier, President, Colorado State College of Education, Greeley, Colo.
Address: The Spiritual Values in the Profession of Nursing, Rabbi Abba Hillel Silver, D.D., The Temple, Cleveland, Ohio

N.O.P.H.N. PROGRAM

Saturday and Sunday: Institutes*

Sunday and Monday: Registration

Tuesday: 9:00-10:30 A. M.
N.O.P.H.N. General Session—Family Health Service
Address: Family Health—The Goal of All Public Health Work
Address: Social Planning for Family Health
10:45-12:00
N.O.P.H.N. Business Meeting (Open only to 1938 N.O.P.H.N. members, by membership card.)
Luncheon: N.O.P.H.N. Membership Rally
2:30-4:00
N.O.P.H.N. General Session—Content of Family Health Service
Address: The Public Health Nurse as a Teacher
Address: Mental Hygiene of the Family
Address: Nutrition of the Family
4:30-6:00—Board and Committee Members' Section Business Session

Wednesday: 10:45-12:00 A. M.
Group Discussion Meetings
Administrators large agencies
Administrators small agencies
Supervisors urban agencies
Supervisors rural agencies
Staff nurses urban
Staff nurses rural
Board members
Industrial nurses

*See PUBLIC HEALTH NURSING, January 1938, page 54.

School nurses
Supervision of midwifery
Orthopedic care
Luncheons:
School Nursing Section Business Session
Industrial Nursing Section Business Session
Dinner: Board Members
Address: To be announced

Thursday: 10:45-12:00 A. M.
Summaries of Group Discussion Meetings from the previous day.
2:30-4:00 P. M. N.O.P.H.N. General Session—Communicable Disease
Address: The Public Health Nurse in the Control of Acute Communicable Disease
Address: The Public Health Nurse in the Control of Tuberculosis
Address: The Public Health Nurse in the Control of Syphilis and Gonorrhea

Friday: 9:00-10:30 A. M.
General Session—Maternity and Orthopedic Service
Address: New Developments in Maternity Programs
Address: Preventive Aspects of the Orthopedic Service
10:45-12:00 N.O.P.H.N. Business Meeting

Other meetings will be announced.

Demonstrations and some additional round tables are planned for the late afternoons in the period from 4:30 to 6:00 p. m. One of the subjects to be discussed at these meetings will be publicity; others will be announced at a later date.

For tentative programs of the American Nurses' Association and the National League for Nursing Education, see *The American Journal of Nursing* for February.

A more complete N.O.P.H.N. program will be published in the April number of PUBLIC HEALTH NURSING.

APPOINTMENT OF MANAGER

The Biennial Convention Headquarters Committee announces the appointment of Jannett G. Flanagan, R.N., of Jefferson City, Missouri, as manager for the Biennial Convention at Kansas City. Miss Flanagan will undertake her new duties at National Headquarters on February 7 and move to Kansas City in March in time to make all local arrangements for the three national nursing organizations.

TRANSPORTATION CHAIRMEN

Nurses and laymen who are planning to attend the Biennial Convention may obtain information about railway transportation by writing to the chairman on transportation in their state.

Murial Kraig, Instructress of Nurses, Baptist State Hospital, Little Rock, Ark.

Harriot L. P. Friend, Director, California State Nurses' Assn., 609 Sutter Street, San Francisco, Calif.

Margaret K. Stack, School of Nursing, Bridgeport Hospital, Bridgeport, Conn.

Gertrude M. Thompson, Ass't Exec. Secy., District of Columbia Graduate Nurses' Assn., 1746 K Street, N.W., Washington, D. C.

Mary A. Moran, 1313 Clayton Street, Wilmington, Del.

Mrs. Augusta Simril, 23 West 21 Street, Jacksonville, Fla.

Durice Dickerson, Executive Secretary, Georgia State Nurses' Assn., 131 Forrest Avenue, N.E., Atlanta, Ga.

Mrs. Bertha F. Goodman, 4447 Greenwood Avenue, Chicago, Ill.

Helen Teal, 717 Circle Tower, Indianapolis, Ind.

Ann Wilkinson, 2028 Ripley Street, Davenport, Iowa

Mrs. Myrtle C. Applegate, 604 S. Third Street, Louisville, Ky.

M. Georgina Barbin, 489 State Street, Bangor, Maine

Martha O. Sayles, Assistant Secretary, Massachusetts State Nurses' Assn., 420 Boylston Street, Boston, Mass.

Mrs. D. A. Foote, Executive Secretary, Nebraska State Nurses' Assn., 626 Electric Bldg., Omaha, Nebr.

Mrs. Agnes K. Fraentzel, New Jersey State Nurses' Assn., 17 Academy Street, Newark, N. J.

Emily Hicks, Executive Secretary, N. Y. State Nurses' Assn., 152 Washington Avenue, Albany, N. Y.

Mrs. H. S. Battie, 603 North Green Street, Greensboro, N. C.

Mrs. E. P. August, General Secretary, Ohio State Nurses' Assn., 50 East Broad Street, Columbus, Ohio.

Mrs. Linnie Laird, Executive Secretary, Oregon State Nurses' Assn., 304 Stevens Bldg., Portland, Oregon.

Annie M. Earley, Executive Secretary, R. I. State Nurses' Assn., 381 Angell Street, Providence, R. I.

Nellie C. Cunningham, 306 Caroline Life Bldg., Columbia, S. C.

Mrs. Abbie L. Starkey, President, Vermont State Nurses' Assn., 3 Nelson Street, Montpelier, Vt.

Mrs. Jessie W. Faris, Executive Secretary, 3015 East Broad Street, Richmond, Va.

Sara Hamilton, Superintendent of Nurses, McMillan Hospital, Charleston, W. Va.

Mrs. Kathryn Savage, 105 West 15th Street, Casper, Wyo.

JOINT VOCATIONAL SERVICE

announces December 1937 placements and assisted placements as follows:

PLACEMENTS

Ella Alethea Hunt, Assistant Supervisor, Visiting Nurse Association of Wilmington, Wilmington, Del.

Grace Rood, Nurse-Teacher, Pine Mountain Settlement School, Pine Mountain, Ky.

Mrs. Sarah B. Lyance, County Nurse, Josephine County Health Unit, Grants Pass, Oreg.

Dorothy Condon, Field Nurse, State Department of Health and Welfare, Augusta, Maine.

Louise Seiler, Public Health Nurse, New York State Department of Health, Albany, N. Y.

Veronica Welsko, Temporary Itinerant Nurse, American Red Cross Nursing Service, Smith's Island, Md.

To staff positions:

Ellen Black, Judson Health Center, New York, N. Y.

Grace M. Carpenter, Metropolitan Life Insurance Company, Haverstraw, N. Y.

ASSISTED PLACEMENTS

Clara Wallace, Harrisburg Chapter, American Red Cross, Harrisburg, Pa.

Eleanor Mumford, Consultant Nurse, National Society for Prevention of Blindness, New York, N. Y.

Ora Belle Crow, Temporary Field Supervisor, Connecticut State Department of Health, Hartford, Conn.

Nina Helen Phelps, Field Supervisor, U. S. Indian Service, Washington, D. C.

Mrs. Gladys Wright Dickinson, Community Nurse, Cornwall Public Health Nursing Association, Cornwall, Conn.

Myona Morrison, County Nurse, Crowley County Health Department, Ordway, Colo.

Mrs. Ruby Howson Granger, Public Health Nurse, Tulare County Health Department, Visalia, Calif.

Beatrice Hoyt, Public Health Nurse, New York State Department of Health, Albany, N. Y.

Esther Bacon, Orthopedic Nurse, Division of Crippled Children, State Department of Public Welfare, Sante Fe, N. Mex.

HIGH POINTS in SCHOOL HEALTH ...

COMMON SKIN DISEASES IN THE SCHOOLS

The control of minor contagious diseases is an ever-present problem wherever children gather together in large groups. Any plan for control must be efficient and not too time-consuming. The program of the New York City school health service is described here.

AT THE TIME when school nursing was started in New York City in 1902 the most obvious need was for the control of communicable disease. Many children were out of school because of infectious eye and skin diseases and other conditions which made them a source of danger to other children. They frequently remained at home and even played about the streets for many weeks or months without receiving proper medical attention, and moreover they were deprived in the meantime of their opportunity for education.

The communicable disease situation in the schools today is quite different from that in 1902. Now there are relatively few infectious eye and skin diseases found in the schools, due probably to more satisfactory home conditions, to health education resulting in better personal hygiene, and to the school health program for early discovery and follow-up of cases.

Fewer cases of any contagious disease mean fewer opportunities for new infections. Today, if a child has a contagious skin condition, as a rule he is allowed to remain in school providing he is kept under treatment which prevents the hazard of infecting others. Even when acute communicable diseases are prevalent, schools are not usually closed. Well children are kept in school and a careful inspection is established to detect any child with symptoms which might indicate the early stages of one of these diseases. Until the last few years a periodic routine classroom inspection by the nurse was used as a method of detecting minor contagion. These conditions now occur less frequently, and much of the credit must go to the teachers, who have acquired great skill in detecting such conditions.

AID OF TEACHERS INDISPENSABLE

At the present time, the teacher makes a daily inspection of her class, with the result that many teachers have become health conscious and are taking extra-curricular health courses. And while the teacher is neither prepared nor expected to make an actual diagnosis of any medical condition, she *is* able to select such cases as seem to demand immediate attention.

We try to impress two things upon the teacher. First, when in doubt send the child to the nurse; and second, it is better to be too careful than sorry. The teachers refer children with suspicious symptoms to the school nurse for a more

careful inspection, and this teamwork is largely responsible for keeping these conditions under control.

The nurse's visit to the classroom as now carried on is really a health inventory. She discusses the individual child with the teacher, and together they plan for the best health interests of the pupils. When the nurse discovers an abnormal number of cases of any skin disease in any class or school under her supervision, she refers the matter to the school physician and makes a daily inspection of the class or classes until the condition has cleared up.

There are certain skin diseases which are apt to occur among the children of a large city such as New York. The most common skin diseases with which the school nurses come in contact are: pediculosis, ringworm, favus, scabies, and impetigo. These cases are found among the children referred to the school physicians and nurses by the principals and teachers, and they are also discovered by the nurses themselves during their health inventories in the classrooms. Sometimes they are discovered by the doctor when he is making physical examinations.

EARLY RECOGNITION AND TREATMENT

The state law requires that all diagnoses of disease must be made by a physician, and therefore a nurse is not permitted to make a diagnosis. But the importance of the recognition of early symptoms and early control and treatment of disease cannot be overestimated, and that is the nurse's part in the program.

When a nurse sees a rash on a child, what is she to do? How is she to decide whether or not to recommend that the child be excluded from school? She may suspect a communicable disease such as measles, German measles, scarlet fever, or chickenpox, or a contagious or non-contagious skin disease. The communicable diseases such as those listed above may easily be confused with common skin diseases. In such cases the thermometer may be used as a guide; when an abnormal temperature is found it is apt to indicate the acute communicable disease.

A nurse must be trained to note the signs and symptoms of contagion in order that she may be able to decide whether the symptoms discovered in a child warrant recommendation for exclusion from school. This really requires special training—repeated opportunities to observe actual rashes and also slides and pictures of cases. The latter are an excellent supplement even if the nurse has viewed a number of cases. Some of the most formidable looking rashes may be non-contagious, while other apparently inoffensive rashes may be highly contagious skin conditions—contagious both from one part of the body to the other and from one individual to another.

HEALTH PROTECTION AT SCHOOL

At school a child must be guarded not only against the acute communicable diseases, but against the minor contagious diseases of the scalp, skin, and eyes.

When these conditions are found, suspicious cases are referred to the family physician or clinic, and a notice is sent to the parents that the child is excluded from school until he receives treatment. If at the end of a given time, the child returns with no evidence of treatment, the doctor or the nurse refers the child to the principal for exclusion, and another notice is sent to the parents stating that the child is apparently suffering from a contagious disease and will not be readmitted to school until he presents a certificate that he is free from contagion.

It is the nurse's responsibility to detect a suspicious condition, but the diagnosis rests with the doctor. When a positive diagnosis is made, either by the school doctor or a private physician, the nurse advises the parent as to the

methods of carrying out the prescribed treatment. This instruction may be given either in the school or the home.

When a communicable disease is discovered and diagnosed, all other children in the family are located in their various classes and are carefully examined for symptoms of the same condition. All cases and contacts to cases are excluded and listed, and each inspection and instruction and exclusion noted until the case is discharged as cured.

The most common skin diseases will be discussed individually.

PEDICULOSIS

Pediculosis of the scalp is due to the presence of an animal parasite, the *pediculus capitas*, or louse. All children with live pediculi are referred to the principal and recommended for exclusion. In addition to the pediculi, which may be readily found, their ova or "nits" are always to be seen upon the shaft of the hairs, quite firmly attached. They are dirty white or greyish looking, minute, pear-shaped bodies, visible to the naked eye. The diagnosis is readily made, and even when they exist in small numbers the nits will indicate the presence of the infection.

When a child apparently infected with pediculosis, is referred to the nurse by the teacher for advice, the nurse's part in the program is to verify the teacher's suspicion and to make some plan for treatment. The parent is sent a notice giving printed instructions regarding such treatment; in cases where he has an unpleasant emotional reaction to a diagnosis of pediculosis, he is invited to the school to discuss the matter.

The New York Department of Health has a standard form for treatment. It consists of the application of equal parts of sweet oil and kerosene, followed after six or eight hours by a shampoo of bicarbonate of soda solution (one teaspoonful of soda to two quarts of warm water), washed out with castile soap and water. The nits are combed out before the shampoo. If properly applied this is usually effective. Tincture of larkspur may be substituted for the oil mixture.

RINGWORM AND FAVUS

Ringworm is due to the invasion of a vegetable fungus. It begins with irregular scaly patches and since the infection spreads in the periphery and heals in the center, the patches tend to assume a ringlike appearance. The central portion is of a dull pink or pale reddish color, and the border is slightly elevated. Slight itching may or may not be present. The face, neck, and backs of hands are the most usual seats of infection.

Ringworm of the scalp is characterized by a circumscribed area of partial baldness with evidence of disease of the hair. Small round scaly patches occur upon any portion of the hairy scalp and the hair falls out.

These cases, particularly ringworm of the scalp, are always referred to private physicians or clinics for treatment. Milder cases may attend school if they follow instructions; otherwise they are recommended for exclusion from school.

The question arises, how would the nurse distinguish favus from ringworm? A nurse would not attempt to do so, even though she suspected favus. She would follow the same procedure as for ringworm. Favus is another vegetable parasitic disease of which the usual seat is the scalp. It is characterized by yellow, cup-shaped crusts about the hair follicles. The word *favus* means honeycomb, a word which describes the appearance of the crusts. The infection results in brittleness and loss of hair.

Children with scalp lesions who are under treatment, whether the infection be ringworm or favus, may attend school.

While the Department has standing orders for the treatment of mild cases, the nurses make every effort to refer

them to a private physician or clinic. X-ray treatment, which must be given by an expert, has proven valuable. Care to prevent reinfection or cross infection from the use of brushes, towels, and caps must be emphasized and the patient should sleep alone.

SCABIES

Scabies, or the itch as it is commonly called, is due to an animal parasite. It is contagious to a marked degree, and is most commonly contracted by sleeping with those affected, or by occupying a bed in which an affected person has slept. Due to overcrowding, it is more prevalent among the poor, but is also found among the more privileged classes. In children at school it is observed mostly between the fingers, on the wrists, and in the folds of the axilla, though it occurs elsewhere on the body. The face is never affected except sometimes in small infants. The burrows of the itch-mites are a dark grey or blackish threadlike formation, varying in length from one-eighth to one-half inch. The itching is intense, especially at night, and there is usually some inflammation due to scratching.

The prognosis is favorable. The disease is readily cured by the well known sulphur ointment treatment and by other types of treatment. Overtreatment may result in dermatitis. As soon as the ova and parasites are destroyed, the itching and symptoms rapidly disappear. Children having this condition are referred by the nurse to their physician or a clinic for proper treatment. She gives instructions regarding the carrying out of the treatment ordered by the physician. If the treatment is not followed, the children are recommended for exclusion from school.

IMPETIGO

Impetigo is one of the commonest of skin diseases, and usually is simple to diagnose, and easy to cure. It is a microbic infection usually caused by streptococci, and is highly contagious. It is characterized by flat vesicles or blebs, which soon become pustular and dry upon the skin as thin crusts. These crusts are commonly seen on the face and hands, and epidemics are common in institutions for children and in summer camps. Impetigo should ordinarily be cured in from one week to ten days.

The treatment consists in the removal of the crusts with tincture of green soap, using gauze which is to be burned, and the application of a prescribed ointment (ammoniated mercury 10% is commonly used) which is left on the surface day and night. It is important to avoid infection of others and of other parts of the body. The treatment is sometimes done in the office of the school nurse when the school physician says the case is mild and requires only one or two treatments, and when conditions are such as to warrant treatment in school.

Quartz lamp and x-ray treatments are used by some physicians to shorten the course of the disease. Cases are referred to the family physician or clinic. The child is allowed to remain in school if he is under treatment and the lesions are covered.

NURSE'S PART IN PROGRAM

To summarize, with the exception of pediculosis no positive diagnosis is ever made by the nurse of any disease. A suspicious condition is referred by her to the family physician or clinic physician, who makes the diagnosis, determines the severity of the case, and outlines the necessary treatment. If exclusion from school is not advised, the nurse's part in the program is to see that the doctor's orders are being carried out.

And now let us turn back the calendar and see what results have been obtained by the type of control described. A few comparisons will show how conditions have improved since that time.

In 1914 the school nurses found 42,522 cases of skin disease among

school children. In 1936—with a much greater school enrollment—they found only a little more than 25% of that number (11,440 cases). The drop in the number of instances where pediculosis was noted by the nurse is ever so much greater. The 6430 cases noted in 1936 are less than 3% of the 246,193 which were found in 1914.

REFERENCES

Schamberg, Jay Frank, and Wright, C. S. Compend of Diseases of the Skin. P. Blakiston's Son and Company, Philadelphia, ninth edition revised, 1934.

Stokes, John H. Dermatology and Syphilology for Nurses. W. B. Saunders Company, Philadelphia, second edition reset, 1935.

Sutton, Richard Lightburn, and Sutton, Richard Lightburn, Jr. Diseases of the Skin. C. V. Mosby Company, St. Louis, ninth edition revised, 1935.

Walker, Sir Norman. Introduction to Dermatology. William Wood and Company, Baltimore, eighth edition revised, 1925.

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Miss Cohen is Superintendent of Public Health Nurses in charge of personnel records and staff orders in the Bureau of Nursing. At the time this article was written, she was in charge of school nursing.

TOWARD SAFETY IN SCHOOL BUSES

A special commission on school buses created in Massachusetts in 1931 arrived at the following recommendations for legislative purposes:

1. Defining as a school bus, a motor vehicle used for the transportation of school pupils, carrying six or more persons.

2. Periodic inspection of school buses by the registrar of motor vehicles.

3. A minimum age limit of 21 years for operators of school buses.

4. Regulation providing that no fuel shall be taken aboard while occupied by school children.

5. That all school buses shall be prominently identified as such.

6. That emergency doors shall be provided for each bus, located in the rear.

7. That doors of all school buses shall be kept closed while the vehicle is in operation.

8. Adequate protection from inclement weather must be provided.

9. School buses shall be provided with iron window grating for the added protection of occupants.

10. A maximum speed limit of 30 miles an hour for school buses.

11. Every school bus must stop not more than 100 feet from a grade crossing.

12. Overloading of school buses limited to 25 percent of capacity of vehicle.

13. Raising statutory $5000 compulsory automobile insurance liability as pertaining to school buses to require owners to take policy providing not less than $10,000 liability in case of 1 person being injured, and not less than $20,000 liability in case of 2 or more persons being injured.

—From "The Automobile and the School Child," by James Frederick Rogers, M.D., *School Life*, June 1935.

Minimum qualifications for school nurses are outlined on page 108

EDITED BY
ELEANOR W. MUMFORD

FOUR PAPERS ON PROFESSIONAL FUNCTION

By Wayne McMillen, Virginia P. Robinson, Dorothy C. Kahn, and Grace F. Marcus. 59pp. American Association of Social Workers, 130 East 22 Street, New York, N. Y., 1937. $1.

The sincere analysis of social work as a profession and its functions as such presented in the four papers of this pamphlet hold much for us in the field of nursing. "The identifying attributes of a profession are," says Wayne McMillen in the first paper, "the possession of a special body of knowledge, and second, a strong sense of obligation to place this asset at the disposal of the community." This involves such questions as the education and qualifications of the members of the profession, the acquisition of a special body of knowledge through research, well kept records as resources for research possibilities, and the development of leadership in making the fruits of the profession available in the interest of social welfare. The pamphlet discusses admirably these questions with which nursing is also concerned.

V. J.

RESEARCH MEMORANDUM ON SOCIAL ASPECTS OF HEALTH IN THE DEPRESSION

By Selwyn D. Collins and Clark Tibbets. 192pp. Bulletin 36, Social Science Research Council, 230 Park Avenue, New York, 1937. $1.

One of a series of monographs on studies in social aspects of the depression. Several have already appeared relating to various aspects other than health, such as crime, education, and recreation. The purpose of these studies is stated to be three-fold: (1) locating existing data and interpretations already well established (2) discovering serious inadequacies in information (3) formulating research problems feasible for study.

In this volume the relation between economic status and health is discussed from the standpoint of the health indices, mortality, illness, and nutrition; from the standpoint of the health environment, which includes a consideration of living standards, consumption of food and clothing, and housing; and also from the standpoint of the receipt of care—both preventive care and treatment for illness. It is a valuable reference source for studies which already have been made, and for suggestions for further research studies related to these aspects of the health problem.

A.J.M.

CHILD MANAGEMENT

By D. A. Thom, M.D. 107 pp. Bureau Publication No. 143, U. S. Children's Bureau, Washington, D. C., revised, 1937. For sale by the Superintendent of Documents, Washington, D. C., 10c.

This very useful little handbook is a revision of the one published in 1928. Some of the subjects have been enlarged upon and many new ones added. Dr. Thom has included a chapter on the mental approach to the problem of child management. He has also added the following which deal with the adjustments between the child and his environment: the independence of the child, rewards and punishments, stuttering, selfishness, and self-deception. He discusses briefly in the chapter, The Role of Intelligence, "what part intelligence plays in guiding everyday conduct and how essential it is to recognize at the earliest possible date any deviation

from the normal." Another important topic which has been included is The Child During Sickness and Convalescence.

Public health nurses will find this pamphlet a valuable addition to their library, especially since the Children's Bureau has had it printed in larger and clearer type than the 1928 edition.

M.C.L.

CHILD STUDY COURSE

A Course of 24 Lessons for Home Study

By Grace Langdon, Ph.D. The Parents' Institute, 9 East 40 Street, New York, N. Y., 1937. $16.50 for the complete set; or $2 a month for nine months.

Dr. Langdon has written for the publishers of *Parents' Magazine* a home study course consisting of 24 lessons on the care of babies and the training of young children. To mothers who enroll for the course, one lesson in pamphlet form is sent as often as once a week, with test questions for each lesson which the mother sends in to be graded by child specialists. A certificate is awarded for successful completion of the course.

The pamphlets are very clearly and simply written and will be of practical help to individual mothers. Public health nurses will find them excellent for group teaching material.

It is doubtful whether the grading of tests and one mail consultation on a child's development will make the mother of moderate means feel justified in spending such a large sum for study material which she can get in books for much less. We hope the publishers will find means to make this valuable material available for a much more moderate price.

V. J.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

COMMUNICABLE DISEASES

Acute

PNEUMONIA—ITS CARE AND PREVENTION. John Hancock Mutual Life Insurance Company, Boston, 1937. 12pp. Free.

A revision of this attractive pamphlet for the lay public.

SEASONAL PATTERNS AND TRENDS OF COMMUNICABLE DISEASES. Robert Olesen. Public Health Reports, Volume 52, No. 19, May 7, 1937. Superintendent of Documents, Washington, D. C. 5c.

A brief, specific discussion of seasonal characteristics and trends of several common communicable diseases.

THE NEW YORK STATE PROGRAM FOR THE CONTROL OF PNEUMOCOCCUS PNEUMONIA. Edward S. Rogers, M.D. *American Journal of Public Health*, February 1937, pp. 133-141.

An account of New York's pneumonia problem and the organization set up to deal with it.

Tuberculosis

TUBERCULOSIS AMONG NEGROES IN THE UNITED STATES. P. P. McCain. *The American Review of Tuberculosis*, January 1937, p. 25.

Includes a discussion of the place of public health nurses in the program.

THE HOME TREATMENT OF PULMONARY TUBERCULOSIS. C. C. Turner, M.D. *Kentucky Medical Journal*, February 1937, p. 45.

Despite the emphasis on isolation and bed rest, not once is nursing care mentioned.

THE SOCIAL AND VOCATIONAL REHABILITATION OF THE TUBERCULOUS. *Occupations*, April 1937.

This issue is devoted to the rehabilitation of the tuberculous. Seventeen articles upon different phases of this important subject are presented with the coöperation of the National Tuberculosis Association.

THE HOME VERSUS THE PREVENTORIUM IN THE MANAGEMENT OF TUBERCULOSIS CONTACTS. Lewis J. Moorman. *The American Review of Tuberculosis*, March 1937, p. 347.

In this article the conclusion is drawn that desirable results from preventorium care are dependent on adequate follow-up supervision and continuous family education to see that the child does not revert to his former habits as soon as he returns to the home. The

child who learns to make the adjustment in his own home situation, on the other hand, has an equal chance with the preventorium child and is probably better equipped to make further adjustments in his future life.

MANUAL OF TUBERCULOSIS FOR PUBLIC HEALTH NURSES. Issued by the Division of Public Health Nursing and Division of Tuberculosis, State Department of Health, Albany, New York, 1937. 65pp.

Prepared for nurses in New York State.

REPORT OF THE COMMITTEE ON TUBERCULOSIS AMONG NEGROES. National Tuberculosis Association, 50 West 50 Street, New York, 1937. 77pp.

A five-year study and what it has revealed.

TEACHING KITS FOR SECONDARY SCHOOLS. National Tuberculosis Association, 50 West 50 Street, New York, 1937. May be obtained from your state or local tuberculosis association.

Three kits: Historical Approach—Tuberculosis Problem; Statistical Approach—Tuberculosis Problem; Scientific Approach—Tuberculosis Problem. These teaching kits encourage the collection and use of educational materials including those produced locally.

Syphilis and Gonorrhea

SYPHILIS AND SOCIAL SECURITY. William F. Snow, M.D. American Social Hygiene Association, 50 West 50 Street, New York, 1937. 10c.

This reprint from the *Journal of Social Hygiene* not only outlines the basis of social security grants to states for syphilis control but also lists the administrative measures necessary for an effective program and discusses the contribution of private agencies in the development of public opinion.

PROCEEDINGS OF CONFERENCE ON VENEREAL DISEASE CONTROL WORK, WASHINGTON, D. C., December 28-30, 1936. Supplement No. 3, *Venereal Disease Information*, U. S. Public Health Service, 1937. 154pp. For sale by the Superintendent of Documents, Washington, D. C. 15c.

ON YOUR GUARD. THE PREVENTION AND TREATMENT OF SEX DISEASES. Carl Warren. Emerson Books, Inc., New York, 1937. 160pp. $1.

Facts on the control of syphilis and gonorrhea are presented to laymen by a layman. A foreword of endorsement by M. x J. Exner, M.D., Consulting Physician to the American Social Hygiene Association, and the author's acknowledgement to other prominent physicians and health officers vouches for the authenticity of the subject matter.

WHO GAVE THE WORLD SYPHILIS? THE HAITIAN MYTH. Richmond C. Holcomb, M.D. Froben Press, 4 St. Luke's Place, New York, 1937. 189pp. $3.

Another contribution to this controversial subject.

PREVENTING BLINDNESS THROUGH SOCIAL HYGIENE COÖPERATION, Publication 13, 11pp. 10c. ROUTINE WASSERMANN TEST FOR ALL EXPECTANT MOTHERS, Publication 135, 4pp. 5c. SYMPOSIUM ON PRENATAL AND CONGENITAL INFECTIONS IN RELATION TO BLINDNESS AND IMPAIRED VISION, Publication 166, 20pp. 20c. National Society for the Prevention of Blindness, 50 West 50 Street, New York.

Three new publications of the National Society for the Prevention of Blindness showing the relation between social hygiene and the prevention of blindness.

THE NEWEST GENERATION. SOME OF ITS HEALTH RIGHTS AND WRONGS AND WHAT CAN BE DONE ABOUT THEM. William F. Snow, M.D. Publication A-3, American Social Hygiene Association, 50 West 50 Street, New York, 1936. 10c.

SHADOW ON THE LAND: SYPHILIS. Thomas Parran, M.D. Reynal and Hitchcock, Inc., New York, special educational edition, 1938. 309pp. For sale by the American Social Hygiene Association, 50 West 50 Street, New York, $1.

The Association has accepted the exclusive distribution rights of this educational edition. This book may be secured in quantities at a discount.

CONTROL OF SYPHILIS, Thomas Parran, M.D. *Venereal Disease Information*, U. S. Public Health Service, July 1937, p.223. For sale by the Superintendent of Documents, Washington, D. C., 5c.

Dr. Parran defines the problem, discusses the place of the private physician in the control of syphilis, and enumerates the basic principles in a program for control. This article is a good source of factual information that may be drawn upon for local educational programs regarding syphilis.

POSTERS FOR THE SYPHILIS CONTROL CAMPAIGN. Venereal Disease Posters, U. S. Public Health Service. *The Health Officer*, July-August 1937, p.102.

This article describes and illustrates a series

of six editorial posters on syphilis available from the Superintendent of Documents, Washington, D. C. 75c a set.

MEDICAL SOCIAL SERVICE IN A SYPHILIS CLINIC. *Better Times,* December 7, 1936, p.21.

Recommended practices and procedures as drafted by the Committee on Problems of Syphilis Clinics of the Welfare Council Section on Medical Social Service. Edited by Valeria McDermott, secretary.

COMBATTING EARLY SYPHILIS. John H. Stokes, M.D. *Reader's Digest,* March 1937. p.9.

This is the second article on this subject the *Reader's Digest* has published in recent months. Reprints are available from the *Reader's Digest,* Pleasantville, New York, in lots of 100 or more at the rate of $1 a hundred.

SYPHILIS AND SOCIAL SECURITY. William F. Snow, M.D. Publication A-11, American Social Hygiene Association, 50 West 50 Street, New York. 10c.

THE ROLE OF THE DENTIST IN THE CONTROL OF SYPHILIS. R. A. Vonderlehr, M.D. *Journal of the American Dental Association,* December 1937, p.1935.

Presents a very simple discussion of oral syphilitic infections, as well as the part the dentist can play in control.

THE VENEREAL DISEASE CONFERENCE. Editorial. *American Journal of Public Health,* February 1937. pp.178-181.

A concise summary of the significant points of discussion and recommendations made at the venereal disease conference of interested professional and non-professional workers called by Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, in Washington, D. C., December 28-30, 1936.

THE PRINCIPLES OF CASE FINDING. Julia MacPhillips. *Venereal Disease Information,* U. S. Public Health Service, September 1937, p.315. For sale by the Superintendent of Documents, Washington, D. C., 5c.

This article relates to case finding in the control of syphilis but its principles are equally applicable in relation to finding other types of cases.

THE PHILOSOPHY OF CASE HOLDING. Louise B. Ingraham and John H. Stokes, M.D. *Venereal Disease Information,* U. S. Public Health Service. For sale by Superintendent of Documents, Washington, D. C., 5c.

Although written about case holding in syphilis the same philosophy applies in all types of conditions. It is based on the case-work method of adaptation of teaching method and content to individual need.

THE GONORRHEA PROBLEM IN THE UNITED STATES. R. A. Vonderlehr, M.D. and Leda J. Uselton, p.1425. GONOCOCCIC INFECTION. C. M. Carpenter, M.D., p.1428. ARTIFICIALLY INDUCED FEVER FOR THE TREATMENT OF GONOCOCCIC INFECTION IN THE MALE. Stafford L. Warren, M.D., Winfield W. Scott, M.D., and Charles M. Carpenter, M.D., p.1430. *The Journal of the American Medical Association,* October 30, 1937.

GONORRHEA AND SYPHILIS IN INDUSTRY. Nels Nelson, M.D. The Massachusetts Society for Social Hygiene, Boston, 1937. 8pp.

This leaflet is written in the simplest possible language and uses cases to illustrate proper and improper handling.

Other Social Hygiene Materials

JOURNAL OF SOCIAL HYGIENE, American Social Hygiene Association, 50 West 50 Street, New York.

May 1937.

This issue of the Journal is presented to "the devoted, industrious, and skillful disciples of Florence Nightingale, Jane Addams, and other pioneers in these professions." Contains articles on problems for social agencies, clinic practices and procedures, prenatal syphilis, and other phases of syphilis control.

November 1937.

This issue of the *Journal of Social Hygiene,* which is called the youth number, is devoted very largely to the subject of sex education, presenting the social hygiene programs of both the Y. W. C. A. and the Y. M. C. A. as well as the church program and parent education in the field. This is an excellent reference on methods and sources for sex education teaching.

A TALK TO THOSE ABOUT TO WED. Addison W. Baird, M.D. The Addison Press, 12 East 86 Street, New York, revised 1937. 16pp. 25c.

A SOCIAL HYGIENE MESSAGE TO ALL AMERICANS. Publication A-17, American Social Hygiene Association, 50 West 50 Street, New York. Free.

THE SOCIAL HYGIENE BOOKSHELF FOR 1937. A Selected List of Social Hygiene Books and Pamphlets for Home and Public Libraries. *Journal of Social Hygiene,* June 1937, p.314.

• Dr. Jean Broadhurst, Professor of Bacteriology at Teachers College, Columbia University, has recently discovered that by a special staining technique, inclusion bodies may be found in cases of measles. They occur in cells from the mucous membranes of the nose and mouth and are accompanied by definite evidence of cellular deterioration. Apparently, they do not occur except in measles and, as they may be found before the rash appears, this relatively simple staining technique should prove very useful in differentiating early measles from other acute respiratory infections. Dr. Broadhurst's paper on this subject was published in the September-October issue of the *Journal of Infectious Diseases*.

• Medical, nursing, and other health groups are in the forefront of planners for Social Hygiene Day on February 2. Indications from all parts of the country point to a record number of meetings, forums, and other demonstrations. The practical measures for effective syphilis control are being stressed by speakers on these programs everywhere.

Reports show that on many fronts legislative bodies in the states and municipalities are directing their attention to effective laws and ordinances designed to curtail the spread of syphilis and other venereal diseases. Notable among these activities are two which are now commanding a great deal of public attention in New York State.

The Desmond Bill, which is beginning its legislative career in New York, will require the blood test and medical assurance of freedom from infectious syphilis before marriage licenses can be issued. Another New York bill was recently introduced to require physicians attending confinement cases to do a Wassermann or other standard serological test during routine antepartum examinations.

These activities are a direct outgrowth of an awakened public interest and reflect the efficacy of continued promotion of sentiment and for sound safeguards in the war against syphilis and the conditions which favor its spread.

An interesting tabloid newspaper which is appropriately called the "Youth Extra" has been published by the American Social Hygiene Association for Social Hygiene Day. Profusely illustrated and interestingly written, this feature is offered free for distribution at meetings.

For further information or supplies, address The American Social Hygiene Association, 50 West 50 Street, New York, N. Y.

• On November 17, the Visiting Nurses of San Diego celebrated the beginning of the eighth year of organized visiting nursing in San Diego by holding a large dinner, in which members of District 8 of the California State Nurses' Association and Unit 3 of the California State Organization for Public Health Nursing participated. The keynote of the meeting was sounded by the Rev. Canon C. Rankin Barnes, rector of St. Paul's Episcopal Church and a nationally known figure in social work, who reviewed the development of public health nursing in the United States in the past fifty years, and declared that the visiting nurse has become a potent influence in the prevention of disease and the teaching of health.

• The following regional conferences under the auspices of the National Association of Colored Graduate Nurses will be held during 1938. Nurses are asked to notify the chairman of their region if they plan to attend. Organizations in each region are expected to send a representative.

Feb. 25, 26—Southern Conference in Fort Worth, Tex. Chairman, Mrs. A. B. S. Miller, 1104 East 2 Street, Fort Worth
March 4, 5 (Tentative)—West Central Conference in Indianapolis, Ind. Chairman, Mary E. Sales, 404 West 28 Street, Indianapolis
March 26, 27—Northeastern Conference in Orange, N. J. Chairman, Mrs. Anna Ramos, 535 N. 11 Street, Newark
April 23, 24—Southeastern Conference in Charleston, S. C. Chairman, Mrs. Cora Estues, Brewer Hospital, Greenwood

The program is planned to include a symposium on organization. A session on public health nursing has also been planned.

• The sixty-fifth annual meeting of the National Conference of Social Work will be held in Seattle, Wash., June 26 to July 2.

• The fifteenth annual meeting of the American Orthopsychiatric Association will be held at the Stevens Hotel in Chicago, Illinois, February 24, 25, and 26. Dr. Norvelle C. LaMar, 210 East 68 Street, New York, N. Y., is the Secretary of the Association.

• A survey is being made by Dr. H. D. Kruse, under the auspices of the Milbank Memorial Fund, to determine the extent to which recent advances in the science of nutrition are being applied in practice in this country. The survey will include the nutrition work of health and other agencies—federal, state, and local—and will show how the science of nutrition is being taught to health officers, medical students, nutritionists, public health nurses, and other public health workers. It is hoped that some preliminary results of the survey may be available toward the end of this year. Dr. Kruse is on leave of absence from the School of Hygiene and Public Health of The Johns Hopkins University.

• Three ounces of whiskey, or a little less than two jiggers, are sufficient to render a driver unsafe, according to studies made with a new type "chemical breath smeller" which was developed in the laboratories of Indiana University and reported by Dr. Rollo N. Harger. Dr. Harger, who is Professor of Biochemistry and Toxicology at the University of Indiana, gave the estimate based on these studies at a talk before a group of highway traffic experts at the National Safety Congress in Kansas City on October 12, 1937.

NEW APPOINTMENTS

(For J. V. S. Appointments see page 119)

Dorothy M. Wright, Nurse in Charge, Jesse Isidor Straus Child Health Station, New York, N. Y.
Helen L. Brown, Orthopedic Nurse, State Department of Health, Albany, N. Y.
Elfleda Sprague, Chief Public Health Nurse, Territorial Board of Health, Honolulu, Hawaii.
Alicia E. Bertz, American Red Cross, Washington, D. C.
Agnes Belser, Advisory Nurse, Birth Control Clinical Research Bureau of New York, New York, N. Y.
Blanche E. Seyfert, Community Visiting Nurse, Community Health Association, Ephrata, Pa.
Nadine Geitz, Consultant Nurse, American Social Hygiene Association, New York, N. Y.
Mrs. Edith G. Peters, County Nurse, Jackson County Health Department, Maquoketa, Iowa.
Anna N. Fellows, Supervisor of Public Health, Mt. Alto Sanatorium and Elizabethtown Crippled Children's Hospital, Penna.
Marie S. Jepson, Public Health Nurse, Berks County, Reading, Pa.
Mrs. Dolly Bigler, Instructor, Maternal Health and Child Hygiene Division, State Department of Health, Wisconsin.

An examination for Junior Graduate Nurse, $1620 a year, for the U. S. Public Health Service and the Veterans' Administration is announced by the U. S. Civil Service Commission, Washington, D. C. Applications should be on file by February 10 from Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming; by February 7 for other states.

Study Page for February

Suggestions for Board Members, Executives, Staff Nurses, and Students

The following questions are based on the published material in this number, and offer suggestions for the use of the magazine:

Board Members

What Can the Layman Do to assume leadership in regard to the adjustments that are necessary in meeting today's social problems? Page 89.

How does pneumonia rank as a cause of deaths? What is the part of the public health nurse in its control? *Public Health Nursing Aspects of Pneumonia Control.* Page 74.

How would you answer these questions on student affiliation with a public health nursing agency? See *Student Affiliation.* Page 72.

What was the purpose of the recent Washington Conference on *Better Care for Mothers and Babies?* Page 71.

Executives and Supervisors

What are the functions of the public health nurse in pneumonia control? See question 2 under Board Members.

What are your problems in regard to student affiliation? See question 3 under Board Members.

What prerequisites are necessary for effective board membership? See question 1 under Board Members.

What types of uniforms are being worn by public health nurses? *Uniforms Keep Up to Date.* Page 105.

What outcomes are hoped from the Washington Conference on *Better Care for Mothers and Babies?* See question 4 under Board Members.

Staff Nurses

What are some important dietary needs of the antepartum period? Of lactation? Of infancy? *Nutrition and the Maintenance of Health.* Page 79.

What does the N.O.P.H.N. mean to you? A public health nurse answers this question in the essay which won a life membership. *What the N.O.P.H.N. Means to Me.* Page 101.

What opportunities has the industrial nurse to reduce preventable illness in the plant? *The Industrial Nurse's Part in the Prevention of Sickness.* Page 85.

What opportunity has the public health nurse to assist in the control of pneumonia in her community? See question 2 under Board Members.

How can the public health nurse reduce preventable accidents in the home? *The Prevention of Home Accidents.* Page 96.

Student Nurses

What does an industrial nurse do? See question 3 under Staff Nurses.

What are some of the penalties for failure to meet the dietary needs of the body? What things are important in the diet of the pregnant woman? The nursing mother? The infant? See question 1 under Staff Nurses.

How does the public health nurse help in the program of a community for pneumonia control? See question 2 under Board Members.

How does the National Organization for Public Health Nursing help a nurse who is on the job? See question 2 under Staff Nurses.

Does the preventive work of the public health nurse extend to accidents as well as illness? See question 5 under Staff Nurses.

"INFORMATION and LEADERSHIP"

THIS MAGAZINE aims to give its readers two types of material: practical, everyday information on latest methods, devices, books, studies, and news, plus the thinking of leaders on the current problems and developments in public health nursing—in other words, information and leadership.

MONTHLY DEPARTMENTS provide space for specialized material, such as school nursing, and a chance for informal discussion of your problems. Editorials keep you up to date in professional thinking about the effect of the economic changes on public health nursing, its relationship to other fields of social work, and its future. Special numbers give space to maternal and infant health, preschool and school nursing. The best papers from state and national meetings—including the Biennial Convention—are published here.

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